AUTHORIZING SAFETY NET PUBLIC HEALTH PROGRAMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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AUTHORIZING SAFETY NET PUBLIC HEALTH PROGRAMS

THURSDAY, AUGUST 1, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:12 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Burr, Bryant, Ehrlich, Pitts, Brown, Strickland, Barrett, Capps, Pallone, Wynn, Green.

Staff present: Marc Wheat, majority counsel; Anne Esposito, policy coordinator; Nolty Theriot, legislative clerk; Dave Nelson, minority counsel; John Ford, minority counsel; and Cartay Johnson, clerk.

Mr. BILIRAKIS. The hearing will come to order. I would like to start by welcoming our witnesses. I know that it can be difficult to drop everything, as you all have, and you are probably among the busiest people in the country, to come to Washington to testify, especially on such short notice, and we want to thank you, and want to apologize to you but, that is the way things are done up here and that is unfortunate, but that is the way it is.

As I understand it the rules only require a 1-week notice of hearings. We talk with the minority, we do our best to give 2-weeks notice of all hearings. Notices, I suppose, can be done in many ways. There are vocal notices, oral notices, discussion notices, and then there is, of course, the written notice.

I think it is important that we are having this hearing when we are having it because we have an entire month ahead of us when Congress will not be in session and the staffs on both sides of the aisle are so very, very busy these days with the Managed Care legislation, prescription drug legislation, and all the authorizing that we have to do and that sort of thing, so it gives them, I think, uninterrupted by the rest of us to work on a bipartisan piece of legislation regarding the subjects over the recess. So, for that reason, we decided to hold the hearing this week.

I do apologize, as I said earlier, for the short notice to the witnesses and, to a lesser extent, the members for the short notice. But it is important that we begin to look at these serious issues. We can sit back and talk about procedure, and this took place and that took place, and this did not take place, and make an awful lot out of it, but hopefully when we get that out of the way, we can

reach out and shake hands and work together. I trust that that is going to take place. I know that my relationship with Mr. Brown is such a good one that that will be the case.

We are discussing issues related to the programs and professionals that deliver health care services to many of our Nation's citizens. First, we will hear testimony on two vitally important health care programs, the Community Health Center Program and the National Health Service Corps.

The second panel will explore the growing workforce shortages among nurses, pharmacists and medical technologists. And, again, I would like to welcome all of our witnesses and thank them.

Community Health Centers deliver care in rural and urban communities which are designated as medically undeserved because of the inadequate supply of health care providers. That is an especially big cause of mine, I might add. The mission of these centers is to provide both primary and preventive health care. Community Health Centers provide care in 3,000 communities to over 12 billion Americans, regardless of their ability to pay.

The National Health Service Corps also plays a critical role in providing care for undeserved populations. Through the service-obligated and volunteer programs, the National Health Service Corps recruits, trains and places primary care providers, including dentists, nurses and physician assistants, in both urban and rural health care shortage areas. Program participants are health professionals who receive educational assistance in return for a period of obligated service—and I might add at this point parenthetically, that that is something that has bugged me for a long time, the fact that they are able to buy-out of their obligation is something that I don't think they should have the right to do, and Mr. Brown and I might talk a little further about that as time goes on.

The National Health Service Corps plays a significant role in placing providers into areas that have difficulty attracting health professionals. Allied health professionals play a valuable and necessary role in the delivery of high-quality health care. Nurses, pharmacists and medical technologists make up a significant portion of this primary care workforce, and recent evidence suggests that we may have shortages of these important caregivers.

Nurses are a mainstay in today's health care system. Certainly our nurse on this committee, Ms. Capps, is a mainstay in our health care system. These medical professionals on the front lines of care are dedicated to helping patients pull through their most vulnerable moments, and I would like to extend a warm Florida welcome particularly to Linda O'Leary, Chief Nursing Officer, at the Regional Medical Center in Bayonet Point, Florida, in my congressional district. I thank you, Ms. O'Leary, for coming here to share your views with us on the nursing shortage.

As you know, the United States General Accounting Office has reported that there is an emerging shortage of nurses in the country. By 2020, millions of Baby Boomers will be retiring and expecting quality health care as senior citizens. These individuals will need the care and comfort qualified nurses provide, and we must do what we can to ensure an adequate supply of nurses to meet this demand.

In December 1999, in legislation sponsored by Mr. Brown and myself, we requested that the Health Resources and Service Administration complete a study on the pharmacist workforce. HRSA's report to Congress stated, and I quote, "Evidence clearly indicates the emergence of a shortage of pharmacists." When I read in the newspaper the other day the starting salaries, in Florida particularly, of a pharmacist coming right out of pharmacy school—Sherrod, I think we picked the wrong profession.

Pharmacists play an increasing role in the care that many patients receive, and a shortage could negatively impact this care. Pharmacists and their related services help patients with medication compliance, review records to check for drug-to-drug interactions—which are a leading cause of medical errors, as we know—and counsel patients and doctors on medication options. With increased demand in utilization of medication therapies, we must make sure that we have enough qualified pharmacists.

It has been brought to our subcommittee's attention that we are also facing a shortage in the medical technology area. Medical technologists play a crucial role in the detection and diagnosis of diseases by analyzing body fluids, tissues and cells. My wife is a medical technologist. I met her when she was doing this at one of the hospitals back in Florida.

Medicine today and in the future will place increased pressure on medical laboratories to diagnose disease early through the use of advanced screening technology. Therefore, it is imperative that we have trained medical and clinical laboratory technologists to fill this important role.

I would say again, parenthetically—maybe even more for the benefit of Mr. Brown and the minority—I don't know what the solution is to these shortage problems. That is why we hold these hearings so that we can try to get some ideas of how we can address matters such as this.

As health care delivery becomes more complex, we must be sure that we have the trained professionals and infrastructure necessary to address the increasing demand for health care services. And, again, I look forward to hearing from the witnesses today, and would now yield to Mr. Brown for an opening statement.

[The prepared statement of Hon. Michael Bilirakis follows:]

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

This hearing will now come to order. Today we are discussing issues related to the programs and professionals that deliver health care services to many of our nation's citizens. First, we will hear testimony on two vitally important health care programs—the Community Health Center program and the National Health Service Corps. Our second panel will explore the growing workforce shortages among nurses, pharmacists and medical technologists. I would like to welcome all of our witnesses here today and thank them for taking the time and effort to appear before the Subcommittee.

Community Health Centers deliver care in rural and urban communities which are designated as medically underserved because of the inadequate supply of health care providers. The mission of these centers is to provide both primary and preventative health care. Community Health Centers provide care in 3,000 communities to over 12 million Americans, regardless of their ability to pay.

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care shortage areas. Program participants are health professionals who receive educational assistance in return for a period of obligated service. The National Health Service Corps plays a significant role in placing providers into areas that have difficulty attracting health professionals.

Allied health professionals play a valuable and necessary role in the delivery of high quality health care. Nurses, pharmacists and medical technologists make up a significant portion of this primary care workforce. And, recent evidence suggests that we may have shortages of these important caregivers.

Nurses are a mainstay in today's health care system. These medical professionals, on the front lines of care, are dedicated to helping patients pull through their most vulnerable moments. I'd like to extend a warm Florida welcome to Linda O'Leary, Chief Nursing Officer at the Regional Medical Center at Bayonet Point. Thank you for coming all the way from the 9th district of Florida, my district, to share your views with us on the nursing shortage. As you know, the United States General Accounting Office (GAO) has reported that there is an emerging shortage of nurses in this country. By 2020, millions of baby boomers will be retiring and expecting quality health care as senior citizens. These individuals will need the care and comfort qualified nurses provide, and we must do what we can to ensure an adequate supply of nurses to meet this demand.

In December of 1999, in legislation sponsored by Mr. Brown and myself, we requested that the Health Resources and Services Administration (HRSA) complete a study on the pharmacists workforce. HRSA's report to Congress stated that, "evidence clearly indicates the emergence of a shortage of pharmacists." Pharmacists play an increasing role in the care that many patients receive, and a shortage could negatively impact this care. Pharmacists, and their related services, help patients with medication compliance, review records to check for drug-to-drug interactions (which are a leading cause of medical errors) and counsel patients and doctors on medication options. With increased demand and utilization of medication therapies we must make sure that we have enough qualified pharmacists.

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As health care delivery becomes more complex, we must be sure that we have the trained professionals and infrastructure necessary to address the increasing demand for health care services.

I look forward to hearing from the witnesses today. I will now yield to Mr. Brown for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman, I appreciate that. I appreciate the desire of the chairman to bring reauthorization and other legislation to the floor in September when we return. It is a goal that my Democratic colleagues and I strongly support.

I am concerned, however, as the chairman mentioned, about the schedule of hearings, particularly broad-scope hearings and important hearings like this one, on such short notice. Staff for both the majority and the minority should have been afforded at least 2 weeks to prepare. One week is simply not enough with a panel of the stature of this. Of the 13 witnesses, 12 had no written testimony submitted as of midday yesterday, the day before the hearing. That is not the fault of you as witnesses, no formal invitations were sent out until late Monday afternoon. Democratic staff didn't receive confirmation of a critical witness, Dr. Roberts on the second panel, until after 3 on Monday. I specifically ask that the record be kept open to receive rebuttal testimony on the economic positions taken by Dr. Roberts.

Mr. BILIRAKIS. Without objection.

Mr. BROWN. Thank you, Mr. Chairman. I would hope also that in the future we can agree on reasonable notice for complex hearings, suggest to the chairman—and we have talked about this pri-

vately and he has always been very, very cooperative—the chairman of the subcommittee suggest that 2 weeks is a minimum timeframe for proper preparation.

Moving on to the substance, which obviously is of much more concern to the witnesses, I want to thank all of you for testifying today. I want to extend a special welcome to Diana Baker, an R.N. and Assistant Nurse Manager at the Urology/Gynecology Unit at Cleveland Clinic, from Newton Falls, Ohio. We are covering a lot of ground on a number of important issues, including Community Health Centers, the National Health Service Corps, and the shortage of three valuable health care providers—nurses, pharmacists and medical technicians.

There is a misperception in this country that Medicaid offers a health care safety net for all low-income people. Medicaid, though, does not go far enough. In Ohio, 51 percent of uninsured patients are not eligible for Medicaid and virtually none of uninsured nonparents is eligible for Medicaid. National Health Service Corps and Community Health Centers provide health services to an undeserved and uninsured population ineligible for Medicaid, a population that faces poverty, homelessness, poor living conditions, isolation, lack of doctors, all of this obviously poses serious barriers to quality care. These programs together enable us to serve populations that otherwise would fall through the cracks of our patchwork public/private health care system.

The NHS enables health professionals to go where no other health professionals would go, providing access to health care and working to eliminate health disparities in undeserved areas. Reauthorization will make this program stronger.

Earlier this year, the chairman and I circulated a letter to the Appropriations Committee expressing support for increased funding for Community Health Centers. Two hundred nineteen of our colleagues signed the letter, the largest number of House Members ever to support funding for Health Centers. The President has said he is committed to doubling the number of Health Centers over the next 5 years. Congressional bipartisan support for health centers is stronger than ever. Health Centers and the National Health Service Corps continue to improve the quality of life for so many uninsured families.

The second panel will discuss workforce shortages. Many of us on this committee have been working closely with a number of nursing groups, including the ANA, including the Service Employees International Union, and hospital groups on this issue. Right now, the average of employed Register Nurses is 45 years old and increasing. Ominously, the number of graduates from nursing programs declined by 1995 and 1999 almost 14 percent.

My colleague, Congresswoman Capps, has worked very hard on this issue, has kept this issue in front of this subcommittee, in front of this Congress, and I am pleased, as many others are, to be a co-sponsor of the bill she introduced that addresses the long-term critical concerns facing her profession, facing the nursing profession.

As this Congress considers its role, I would urge my colleagues that patient safety should guide our decisions. For every day a hos-

pital floor is staffed with exhausted nurses working overtime, patients' lives are at risk.

Congressman Shimkus has introduced legislation with respect to the shortage of medical laboratory technicians, individuals responsible for such lifesaving work as screening women for cervical cancer and recognizing the resistance of pathogens, more commonly known as anti-microbial resistance.

I also want to thank my colleague, Mr. McGovern, for his diligent work on behalf of the pharmacists shortage issue. Americans filling are more prescriptions today than ever. It is critical that pharmacies are adequately staffed to ensure that patients are familiar with how to use their prescriptions.

Mr. Chairman, in closing, I want to raise an issue that is not being discussed at today's hearing, the Community Access Program, a valuable program that the President has elected not to fund. People praise managed care for coordinating care. The CAP program is a demonstration program that coordinates care for the uninsured. Failure to fund this program creates duplication of services and compromises the potential of safety net providers who could be working together. I hope we look at this issue more closely in the near future, and I thank the chairman for his cooperation at all times.

Mr. BILIRAKIS. And I thank the gentleman. Mr. Pitts, for an opening statement.

Mr. PITTS. Thank you, Mr. Chairman, and thank you for holding this important on public health this morning. It has been my pleasure to coordinate the Public Health Working Group as part of this subcommittee, and to develop legislation that builds on the success of Community Health Centers and provides real solutions to the challenges they face. Community Health Centers provide invaluable medical care to millions of Americans without health insurance, low-income working families, rural residents, agricultural farm workers, and those living with HIV or with mental health needs.

Today, we will hear from experts in public health, those who are in the field every day meeting the health needs of those in their community. I am especially pleased to have with us today Kathy Benjamin, from the Southeast Lancaster Health Services, from my congressional district. I visited the Health Center for the first time several years ago, one of my first site visits after coming to Congress. I then recently visited it again last week.

It is encouraging to see the positive impact they have on the lives of families, especially women and children. The Southeast Lancaster Community Health Center takes seriously its responsibility to serve the surrounding community and the city of Lancaster, and they are successful in providing quality health care. Yet, each day they, along with Community Health Centers across the country, face many challenges, challenges which through this hearing we will have the opportunity to hear first-hand.

While these servants would rather spend their time meeting the health needs of families who come to them, they must spend too much time dealing with the shortage of health care professionals, problems with Medicare and Medicaid reimbursement, community

outreach, inadequate facilities, or limited funding. Their hands are full. We must work diligently to address these challenges.

Further, Mr. Chairman, President Bush has provided a model to build bridges between faith-based organizations and government agencies. There are many such professional Community Health Centers throughout the country that are faith-based, and we must look at ways to empower them to better meet the needs of their community.

I would like to recognize David Winningham, the Director of Development at Esperanza, a faith-based Community Health Center located in northeast Philadelphia, one of the most depressed areas in the city. Esperanza is a poster child for the successes and challenges that faith-based community health services provide. They not only meet the health needs of families in their community, but also seek to impact and change lives. Ask those who work at Esperanza why they do what they do. They will respond that they are compelled by love to serve those in need, and we must work with them. Mr. Winningham has prepared a statement and I would like to submit it for the record, and I encourage everyone to read it.

Mr. BILIRAKIS. Without objection.

[The statement follows:]

PREPARED STATEMENT OF DAVID WINNINGHAM, DIRECTOR OF DEVELOPMENT, ESPERANZA MEDICAL CLINIC

Esperanza Medical Clinic was begun under the leadership of Dr. Carolyn Klaus in 1987. Dr. Klaus, working with a number of concerned health professionals from several urban churches, had discerned a need for a holistic, high quality, and culturally sensitive health care center in North Philadelphia.

Esperanza's (*Hope* in Spanish) main program is operation of a *community health care* clinic to treat and prevent injury and disease. It has a full-time board certified staff of bilingual physicians, nurses, nurse practitioners, and physician assistants specializing in cardiology, pediatrics, women's health, family medicine, internal medicine, and infectious diseases. Health Partners, Inc has deemed Esperanza a "Center of Excellence" for the diagnosis and treatment of HIV/Aids.

Esperanza holistic health care approach focuses on prevention. Patients are educated on a wide variety of issues ranging from diabetes care to coping with depression, from dealing with the welfare system to learning the ingredients of a successful marriage. Almost half of our visits are with children, so we have the opportunity to affect the way the next generation approaches their health care.

Esperanza provides individual and family counseling. In conjunction with their primary health care program, the counseling program works to positively impact the emotional, mental, spiritual, and social health of the community it serves.

Why is this so important? Many of the Hispanics in our community cannot access health care services because of cultural, language, and financial barriers.

- We estimate that 85% of our patients are 100% below the federal poverty line
- 26.9% of the Hispanic births in Philadelphia were to teenage mothers, the highest of any racial group [1]
- 73.7% of all children born to Hispanic mothers answered, "no" to the question, "Is mother married to father?" [2]
- The poverty rate for children under 18 in Philadelphia is 37.5% compared to the U.S average of 20.8%. [3]
- Those receiving welfare (AFDC and TANF) in Philadelphia is 12.5% compared to the U.S. average of 3.6%. [4]

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[1] Philadelphia Dept. of Public Health, Vital Statistics Report 1998
[2] Ibid
[3] American Institute for Research 1995
[4] American Institute for Research 1998

Because all of our medical staff is bilingual, many have or do live in the Culture. Esperanza is a light of hope in North Philadelphia *because no one is turned away because they cannot pay for medical care.*

In Esperanza's last fiscal year, our physicians saw 9,266 patients while our counselors averaged forty-one visits a month. At the beginning of 2000, we were forced to discontinue accepting any new patients. The patient load and examination room availability had reached the maximum level for proper care. In June of this year, we added two physicians and additional medical personnel to our staff and reopened to new patients who are arriving at a rate of almost 300 per month.

Last year, 85% of our patients were either Medicaid or Medicare recipients while 6% were self-pay. The problem lies with the delay in reimbursements from the government. As of this writing, we were still waiting for almost $200,000 in reimbursements from 1999

As with most organizations, payroll and rent are the biggest expenses and Esperanza is no exception. Our staff of physicians and other medical personnel is paid roughly 30-35% of what they could be earning with for-profit organizations. Our rent is reasonable but we could use more space.

It is not unusual for our medical professionals and staff to go without salary beyond the normal pay schedule. Needless to say, it causes financial difficulty for many of our already underpaid staff. Having said this, Esperanza has minimal turnover of personnel because of their overwhelming commitment to the work done here. Those employed at Esperanza believe in its mission and that everyone is entitled to the excellent healthcare provided in our clinic.

Please allow me to tell you just one real-life story of those we serve in North Philadelphia. For the purpose of this testimony, lets call our patient "Maria."

Maria is a young Hispanic woman in her early 20's born and raised in North Philly, a place known by the local police as "the badlands." Her community has this reputation because it has the highest homicidal and suicidal rates in all of Pennsylvania. Crime is rampant, housing is deplorable, and people live in this narrowly defined area where drugs and poverty are the everyday influences with which they must contend.

Although Maria is a second generation Hispanic, she prefers Spanish culture and speaks mostly Spanish. Despite the fact that she is a US citizen, she does not see herself as one with the same rights as other groups enjoy. As with most Hispanics in this area, Maria's experience with social institutions has proven challenging, to say the least. In essence, she has trouble communicating with and does not trust the people who represent these community organizations and has asked for our help with the many difficulties of her existence. Maria is an exemplification of the typical person in North Philadelphia. Her life has been a succession of pain and sorrow. She is the mother of two children, one of which is a three-month old daughter born with both brain and heart damage.

Several weeks ago, Maria called our center in an acute emotional crisis. The only person that had a relationship with her was our head nurse, Andrea. Because the nature of her call was psychological, one of therapist was asked to follow-up. Maria was suicidal.

Maria's husband was working. Her mother was unavailable as she was caring for her other daughter who was recently released from a psychiatric institution. Maria turned to her friends at Esperanza.

We were able to "jump through hoops" in order to get Maria to Esperanza to meet with a team consisting of a pediatrician, a family practitioner, head nurse, and a therapist. Together we were able to assess, make a plan of action, and implement it in order to serve this patient.

Several days later, she was scheduled to meet her therapist at the center. However, when the hour came, her therapist received a call from a very anxious and depressed young woman stating that desperately needed her appointment but could not come for lack of childcare. The therapist responded by saying she would come for the session in Maria's home. Maria was relieved that the staff would go so far as to visit her in her home.

When the therapist arrived for the session, she was astonished by the conditions she saw. The first floor of the house was cluttered with large black trash bags, trashcans overflowing, walls half built and construction materials everywhere. The dust was so awful that it was virtually impossible to breathe. Maria was determined to make this house a "home."

Maria took Liz to the second floor. They decided to have their session while sitting on the bed of the two year old daughter. Directly in front of them was the 3 month old in her crib. She was connected to feeding tubes, which nourished her young body in order to keep her alive. They sat there and talked endlessly as if she had never told anyone about her life and all its difficulties. No support from family. No support

or confidence in social agencies. But now she feels she has an ally. One who understands her culturally and emotionally.

When Liz returned to Esperanza, she came across a local pastor who is supportive of our center. I told him of the need Maria had to have her construction work finished. He joyfully agreed to use a group of teenagers from a suburban church to volunteer their time to serve this family.

This is the holistic nature of the work of Esperanza. It is very difficult to describe the emotional impact that such lives have on its staff. It is true that their trauma vicariously affects us all. But because of the presence of our living God, Who goes ahead of us, we are more than equipped to walk side-by-side with these broken lives.

We are grateful for the funding made available for community health centers in our country. We would not be able to provide the services we do to the citizens of Philadelphia without them. Having said that, we could use your influence to see that the reimbursement process is improved. As I said earlier, we are still waiting on annual wrap-around reimbursements from 1999.

Thank you for the opportunity for me to present the work of the dedicated staff of Esperanza Health Center to his committee.

Mr. PITTS. In closing, the reauthorization of Community Health Centers is an extremely important issue and one that the committee and the House cannot hesitate to address. There are many families and children around the country that need quality health care, it is our responsibility to reach out to ensure that this need is met.

I look forward to hearing the testimony of our distinguished witnesses. Thank you, Mr. Chairman, and I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Ms. Capps, for an opening statement.

Ms. CAPPS. Mr. Chairman, thank you for holding this very important hearing today. I am very pleased that we are focusing on America's public health safety net and, in particular, the shortage of nurses in the workforce, and I have been discussing these related issues with you for some time, and perhaps given the shortness of the notice for the hearing, we can consider this a first step in our discussion of some very important topics.

Clearly, this hearing will deal with important programs, and I hope it will be inclusive of ones like the Community Access Program, which help local agencies coordinate their efforts to provide health care.

In my district, the Lompoc Valley Community Health Care Organization has received funds from this program, and I am proud to support Mr. Green's legislation to authorize the program. But I have a special interest in the nursing shortage. As has been indicated, I have been a nurse, I have been a nurse for 41 years, and have been working on this particular issue in Congress for the past 2 years. I have known first-hand the challenges that my profession faces, and the importance of nurses in my district have also informed my motivation to be involved in this important discussion.

Nurses are the first line of defense in our Nation's health care system, and too often last in line for support. Today the nursing community is facing a dire situation which actually translates into meaning that our society is facing a dire situation. There is an ongoing shortage of nurses in the workplace that threatens access to quality of care for many Americans. To make matters worse, a greater crisis is looming just over the horizon that could strain the health care system to the breaking point. We have an aging nurs-

ing workforce and a dwindling supply of new nurses. Right now, as has been mentioned already, the average age of employed Registered Nurses is 43 years old. By 2010, 40 percent of the R.N. workforce will be over 50. At the same time that so many are approaching retirement, we are facing an incredible shortfall of well-trained, experienced nurses in all fields, and this just as the 78 million members of the Baby Boom generation begin to retire and need a greater amount of health care.

That is why I worked with Representative Sue Kelly and my colleagues here on the Energy and Commerce Committee, especially Representative Ed Whitfield, as well as Ranking Member Dingell and Ranking Member Brown and, in the Senate, Senators Kerry and Jeffords and various nursing and hospital groups, to craft what we are calling the Nurse Reinvestment Act.

Our bill establishes a National Nurse Service Corps to provide scholarships to nursing students who agree to work in health care facilities that are critically short of nurses. We have done this in the past. It is time to do it again.

The bill also provides for public service announcement and nursing recruitment programs to help health care providers and nursing groups promote nursing and caregiving careers, health careers. The Nurse Reinvestment Act also establishes a career ladder grant program to help nurses afford more training and education so that they can advance to the next level of nursing, which also must include training of faculty for nursing education so that schools will be able to help us in this crisis time. And the bill extends Medicare coverage for clinical nurse training to nonhospital providers and increases the Federal Medicaid match for nursing home clinical education of nurses to provide 90 percent of State costs. And, finally, the House legislation provides for grants to develop public/private partnerships between hospitals, nursing schools, and high schools who are maybe interested in health training programs for young people to model after a program just beginning now in my home town of Santa Barbara, which pairs a high school, a local hospital and a nursing school.

This legislation has broad bipartisan support already, with 167 co-sponsors. It has been endorsed by nursing and provider groups across the health care spectrum. These include the American Nurses Association and American Organization of Nurse Executives, the American Hospital Association, the American Association of Colleges of Nurses, the Association of Women's Health Obstetric Neonatal Nurses, the American Health Care Association, the American Association of Homes and Services for the Aging, the Emergency Nurse Association, the National Hispanic Medical Association.

So, it is my hope, Mr. Chairman, that the subcommittee can move this legislation as soon as possible. This hearing I count as our first step along that path, and look forward to working with you on all topics including this legislation.

Mr. BILIRAKIS. I thank the gentlelady. I would like to share with you, Lois, what is happening down in my district regarding the shortage of both nurses and educators, teachers. There is a local community college, a junior college really, for years and years St. Petersburg Junior College was a 2-year school. Just recently they

went to the Legislature and asked to be considered a 4-year college for purposes of offering degrees in nursing and in teaching, and were successful. So, that is kind of their way to try to address these shortages. We have got to look at all ways. Quite often, government is just not enough, and should not be considered enough.

The Chair now yields to Mr. Bryant for an opening statement.

Mr. BRYANT. Thank you, Mr. Chairman, I will be brief. I just want to make a couple of points, and then I know we have had some other people come in who will want to make a statement, but I am eager to hear the panel of witnesses that we have today, and I thank you for being here today and being patient with us as we all wade through these statements.

Two quick points. I represent, in Tennessee, a very diverse district of wealth and come of the more rural counties that are in the State, at the same time, and particularly with the latter I am concerned in the rural communities with the quality of care and the safety net factor that we have talked about and will talk about today.

Second, I would concur with my colleague from California, Ms. Capps, and others I am sure that have mentioned the potential for shortfall that we have with nurses and other technicians and trained medical people out there. I hope we haven't made a serious mistake here in underestimating the need there, and I hope there is time still to correct that.

To the point now, my mother was a nurse, and she is 94, and we are ready to shop her around. If the bonus is right, we might bring her out of retirement.

All she knows how to do, I think, is give penicillin shots. We have advanced a little bit since those days, but with that I will yield back the balance of my time.

Mr. BILIRAKIS. Thank you. Mr. Green, for an opening statement.

Mr. GREEN. Thank you, Mr. Chairman, and I appreciate your holding this hearing on the state of our Nation's health care safety net programs. These programs that are instrumental in our efforts to provide health care for all Americans, even those who can't pay.

Community Health Centers and the National Health Service Corps are central components in our efforts to reach out to underserved Americans. More than 1,000 Community Health Centers serve 11 million Americans in all 50 States. Almost half of the patients served at CHCs are uninsured. These centers deliver comprehensive health and social support services to people who otherwise would face major financial, social, cultural or language barriers to obtain quality and affordable health care.

The National Health Service Corps helps staff these Centers and other safety net providers by giving physicians incentives to serve in low-income and underserved rural and urban communities. Since its founding 30 years ago, the Corps has provided more than 23,000 health professionals to meet the needs of the underserved in these vulnerable populations. These dedicated clinicians also provide primary and preventative care to individuals whose only other source of health care might be the emergency room. Together, these two entities have successfully improved health care in our Nation's rural and inner-city areas. But I don't think we can talk about health care safety net without discussing the Community Ac-

cess Program, and I was concerned with the administration's effort to eliminate this program. Hopefully we can work together to continue this program because it has shown such success in its early life.

And, Dr. Wiltz, I appreciate your testimony and success from Louisiana. Since Mr. Tauzin is not here, I am the only one here that doesn't need an interpreter for somebody from Louisiana, since we speak Cajun and Spanish in Texas, along with whatever else.

The CAP program provides grants to help agencies coordinate preventative and primary care for the 42 million Americans without health insurance. First created as a demonstration project in 2000, CAP grants have helped private and public safety net providers to join forces to improve health care services for the uninsured. And I have introduced CAP legislation—I appreciate the support of my colleagues—that would authorize it for 5 years so we can continue to build on the success we have had this last year. CAP helps fill the gaps in our health care safety net by improving infrastructure and communication among the agencies. With better information, agencies can provide preventative primary and emergency clinical health services in a coordinated and integrated manner.

Mr. Chairman, let me just mention one CAP grantee in Broward County was able to use CAP funds to form an informational health line and referral system to publicize health care prevention and points of access for health care services, and I learned that every day in Houston, if we can have somebody treated with prevention, we can sure save money on our emergency care.

Another program in Chicago, the CAP program has instituted Disease Management with Best Practices, to address the county's disproportionately high mortality rates from diabetes and cancer. Thanks to the CAP program, the consortium was able to reach more than 300,000 residents with these diseases in the Chicago area.

There are many other examples, and I have a report from the National Association of Public Hospitals, which outlines the success of the CAP programs across the country and, Mr. Chairman, I ask unanimous consent to submit that program for the record.

Mr. BILIRAKIS. Without objection.

[The information referred to follows:]

COMMUNITIES IN ACTION: SUCCESS STORIES FROM NAPH CAP GRANTEES

ALABAMA

Jefferson County Department of Health

In Jefferson County, Alabama, the CAP grantee, Jefferson County Department of Health (JCDH) is using its funding to improve continuity of care and access for Birmingham residents and its surrounding areas. The two main objectives of the Jefferson County Community Access Program, known as JeffCoEasy! (Jefferson County's Easy Access to Services for You!) are: (1) to improve access by establishing effective collaboration, information sharing and clinical and financial coordination among all levels of care in the community network and (2) to implement best practices, engage in continuous performance improvement, staff development, and real-time feedback of outcomes of care.

To meet these objectives, JCDH and partner, Cooper Green Hospital, have launched an extensive marketing campaign describing the website, hotline, and resource center to make consumers aware of available health care services. The county also has implemented a unified enrollment and eligibility program for clinics to

assess patients who may qualify for publicly funded programs. Also, they purchased electronic medical record software and modified it to integrate with their current infrastructure. CAP funding is being used to install the electronic medical record at five network sites. This network will allow staff members to track patient medical history, observe important documentation from previous providers, monitor clinic visits and ultimately provide better service and continuity of care. The electronic medical record also features a linking component in which family members' medical records will be coupled together to ease accessibility. Currently, the project is in the piloting stage where they have one site equipped at Baptist Medical Center. At this time, this site is training staff members on using the new software.

For more information on this program, please contact Terry Gunnell at (205) 930-3779 or email him at gunte@jccal.org.

CALIFORNIA

Alameda County Medical Center

In Alameda County, the CAP grantee's goal is to improve continuity of care. Alameda County Medical Center (ACMC) and several collaborative partners, Alameda Health Consortium and its ten member clinics, the Alameda County Health Care Services Agency, the Alameda Alliance for Health, and the Community Voices project, will use their CAP grant to support work on building a county-wide seamless system of care for patients.

They plan to enhance the function of the specialty care coordination unit that currently employs two nurses and two medical clerks. The medical clerks currently make appointments for patients at specialty care clinics. To enhance this activity, ACMC and their collaborators are developing a tracking system that will verify whether patients went to their specialist appointment and allows staff to view what services were received. This program will help decrease the number of referrals by identifying when duplicate services are ordered. Additionally, CAP funding is being used to assure that tile specialist refer the patients back to their primary care physicians for follow up treatment. Furthermore, ACMC is also considering placing select high-demand specialty care services at nonhospital ambulatory care sites in order to improve access to care.

For more information about this program, please contact Ana M. O'Connor at (510) 891-5708 or email her at aocoonor@acmedctr.org.

Contra Costa County

In Contra Costa County of California, Contra Costa Health Services (CCHS) and two community clinics operate the current safety net system of care. In order to increase their capacity to care for the uninsured and underinsured, these organizations are focusing their CAP grant on three objectives: creating an information system to link all the safety-net partner sites to reduce duplication and fragmentation of care, reduce financial and cultural barriers for receiving care, and to identify and implement cost savings through group purchasing.

While early in their program, CCHS is developing software that provides demographic, programmatic, medical, and care reminder information to link programs and partner organizations. Also, this information will provide data that will be used to initiate case management programs for asthma, diabetes, and cellulites. CCHS and their partners are also meeting regularly to combine their resources to better integrate preventive services.

To identify specific financial and cultural barriers, CCHS is conducting a patient survey to identify and assess patient's perceptions about hardships to receiving care, such as language and transportation problems. In examining financial barriers, Contra Costa plans to review existing fee schedules and then establish fees for high-use procedures. Financial counselors can use this information to encourage patients to obtain treatment at a fixed cost. Furthermore, CCHS plans to increase cultural competency among staff and providers by developing training programs that focus on culturally competent disease management. For example, patients from a specific ethnic background may need diabetes disease management programs tailored to their dietary preferences.

To meet their third objective of reducing and containing costs, the partners are negotiating contracts with laboratories, diagnostic imaging services, and pharmaceutical vendors.

For more information on this program, please contact Mary Foran at (925) 370-5055 or email her at mforan@hsd.co.contra-costa.ca.us.

Los Angeles County Department of Health Services (LAC)

The Los Angeles County Department of Health Services is coordinating a CAP grant that includes two projects that use information technology to improve the sys-

tem's infrastructure and access to care. One project is a joint electronic appointment system to allow patients more immediate access to care by coordinating appointments among participating clinics. The second project is a web-based referral system that ties Community Health Centers with high volumes of primary care patients to the County's acute care hospitals that provide specialty care. This project will replace an inefficient system for referring approximately 100,000 patients from Community Health Centers to specialists. LAC is hopeful that they can demonstrate that the web-based referral system improves health outcomes and better utilizes resources.

For more information please contact Ingrid Lamirault at (213) 989-7152 or email her at ilamirault@dhs.co.la.ca.us.

San Francisco Community Clinic Consortium (SFCCC)

The San Francisco CAP grantee is using its funding to improve care coordination and further integrate the public and non-profit safety net health care systems. To meet their goal, the San Francisco Department of Public Health (SFDPH), San Francisco Community Clinic Consortium (SFCCC) and their partners are planning for a common registration system, installing electronic medical record software, standardizing referral systems, and integrating behavioral health care within primary care. These SFCCC clinics refer approximately 40,000 clients annually to SFDPH for specialty, inpatient, and urgent care.

Currently, SFCCC and SFDPH are meeting to develop a common registration system. A taskforce is meeting to assess common registration data and develop recommendations to establish a uniform registration system across the SFDPH community health network (CHN) and the SFCCC sites. This registration system will identify an unduplicated number of uninsured residents who obtain services at both SFCCC/CHN and SFDPH primary care sites. Also, once a patient enters the system, the patient's data will be available for program eligibility determinations. Greater efficiency in the registration process will reduce processing time and delays.

Another integration component is the community health network's electronic medical record, called the Lifetime Clinical Record (LCR). The LCR contains individual clinical information on every client, and is a major step toward a computerized patient record. Currently, the LCR has been installed in one pilot clinic. Since its implementation, the pilot clinic documented improvement in physician morale and staff retention, improved continuity of care, and increased access to care. CAP funding is allowing the LCR to be linked to 10 more clinic sites.

To supplement the LCR system, SFCCC is establishing a referral system between specialists and primary care physicians that is designed to reduce emergency room visits, as specialists will direct patients to their primary care physician to receive follow-up care. Providers at SFCCC and SFDPH will undergo training to reinforce common procedures for referrals.

Along with referral training, primary care providers are attending continuing education sessions conducted by the UCSF Division of Psychosocial Medicine and UCSF School of Pharmacy to learn care techniques for behavioral health problems, limited English speaking patients, and homeless individuals. Primary care physicians at SFCCC have experienced an increase in patients needing treatment for mental health and substance abuse problems. In the past, these patients were often referred to specialists because some primary care physicians lacked training in prescribing, psychotropic drugs. The CAP funding will provide training to primary care physicians in basic behavioral health treatment.

For more information on this program, please contact Dick Hodgson at (415) 345-4230 or email him at rhodgson@sfccc.org.

San Mateo Health Services

In northern California, San Mateo Health Services has formed a consortium with, El Concillio of San Mateo County, AFL-CIO Central Labor Council and the Health Plan of San Mateo in order to strengthen current efforts to maximize the use of California's existing state and federal programs such as Medi-Cal, and to increase enrollment in the Health Services' medically indigent adult program, called the Wellness Education Linkage Low Cost Program (WELL). The partners are enhancing these enrollment efforts by providing low-income residents with access to health education and disease management services. Due to their similar goals, these organizations formed the WELL coalition. CAP funding is supplementing and strengthening the efforts of the WELL Coalition by reaching and enrolling more uninsured families through cultural, community and employer networks.

Since its funding in March 2001, the WELL Coalition has hired six health advocates who are working with the County's Human Service Agency to target uninsured residents and enroll them in available federal and state health insurance pro-

grams. The target populations are uninsured working families, uninsured or underinsured low-income union members, immigrant families, and the medically indigent. In addition, El Concillio and the Labor Council have hired community health workers whose aim is to provide low-wage union members and immigrant families with increased access to health care services through multi-cultural health education, health screening, and prevention. San Mateo is unique in that over 21,000 start-up companies exist with fewer than 20 employees; therefore, these businesses are not required to provide health insurance for their employees. This phenomenon has created an abundance of working families without health insurance. CAP activities along with a California Medi-Cal/Healthy Families outreach grant are financing efforts to assess and reach these individuals and others like them. Through these initiatives, the WELL Coalition is making progress toward their goals of reducing San Mateo County's uninsured population by 35%.

For more information about this program, please contact Toby Douglas at (510) 541-3251 or email him at tjdouglas@co.samateo.ca.us.

COLORADO

Denver Health and Hospital Authority (DHHA)

The CAP grantee from Colorado, Denver Health and Hospital Authority used their CAP grant to facilitate enrollment in publicly funded health insurance and to enhance case management for chronically ill adults with physical, behavioral, and substance abuse problems.

To meet the first goal, the DHHA's CAP program has hired six enrollment specialists to facilitate enrollment of eligible individuals into publicly sponsored programs such as Medicaid, the Child Health Plan Plus (SCHIP), and the Colorado Indigent Care Program. These enrollment specialists take applications from individuals and families in community settings. Once individuals have applied for a program, the enrollment specialists track the status of the applications and perform follow-up procedures.

DHHA's CAP program is making steps toward its second objective through its adult case management program, which aims to alleviate fragmentation of care. For example, this program is designed to improve health outcomes and lower costs for uninsured adult patients who are frequent users of the healthcare system and have physical, behavioral, and/or substance abuse problems. To address this issue, the CAP grantee has hired two case managers, a nurse and a social worker, to identify issues, to access resources, to attend clinic visits, and to develop case management plans for the patients. After the assessment, consenting patients are referred to a *Continuity of Care Clinic* that is designed to care for this high-risk population.

For more information about this program, please contact Liz Whitley at (303) 436-4071 or email her at lwhitely@dhha.org.

FLORIDA

Broward Regional Health Planning Council

In Florida, the goals of the CAP grantee, Broward Regional Health Planning Council, are threefold: to promote a centralized eligibility and referral system to improve access to healthcare services while providing increased awareness of existing resources, to improve data management and case tracking for the uninsured population through an enhanced information management system, and to improve care for the uninsured through better case management. Through these initiatives, Broward Regional Health Planning Council aims to increase enrollment in existing health programs, improve referrals for healthcare needs, and improve health outcomes for targeted health populations such as diabetes, asthma, and HIV/AIDS.

To meet their first objective, the CAP grantee and First Call for Help, Inc. are workin together to form an information health line and referral system that will link community providers to patients in order to publicize healthcare prevention and provide points of access for health care services. Residents of Broward County can access these services by dialing 211 on their telephone.

Along with this goal, Broward County Human Services Department, Memorial Healthcare System, North Broward Hospital District and First Call for Help are collaborating on using new information technology software to improve eligibility determinations for Medicaid, WIC, and KidCare. This project allows health care organizations and caseworkers access to the Broward Information Network (BIN). Caseworkers can use BIN and the new software to identify programs for which patients are eligible. This software can be used to create basic client files also.

In three months of operation, Memorial Healthcare System and North Broward Hospital District have improved care, to vulnerable populations by providing disease management, information about available resources, and linking patients to the

healthcare delivery system. One case manager reports that she has worked with over 150 new clients to facilitate prompt access to care. Another case manager reported that she was able to inform a diabetic patient about the benefits of using new needles for insulin.

For more information about this program, please contact Mike Delucca at (954) 561-9681 x 252 or email him at mdelucca@brhpc.org.

ILLINOIS

Cook County Bureau of Health Services

The Cook County Bureau of Health Services West Corridor Partnership solidifies the public private partnership among the County, the Chicago Department of Public Health, federally funded community health centers, and community hospitals in the Western corridor of Cook County. Through this partnership the over 400,000 uninsured and underinsured residents of these communities will have access to all levels of health care, including much needed sub specialty care. State of the art technology will be employed to insure timely access for appointments, for monitoring and case management to avoid duplication of services, to decrease no-show rates, and provide appropriate sharing of information to provide higher quality and ultimately less costly care.

Disease management "best practices" is also being piloted across the partnership for diabetes care and cancer care and screening. Community residents have higher than the national and County average mortality rates from both diabetes and cancer. Over 300,000 residents will benefit from focused attention on these disease entities.

For more information on this program, please contact Mary Driscoll at (312) 633-8236 or email her at driscoll@hektoen.org.

INDIANA

Health and Hospital Corporation of Marion County

In Indianapolis, the Community Access Program has allowed for expansion of the Wishard Advantage program, which currently provides a full range of health services to 25,000 uninsured individuals, to an additional 8,000 people. Through the collaboration of CAP, the Health and Hospital Corporation of Marion County was able to extend the Wishard Advantage program to include all other safety net providers in the community as partners. This coordinated care to the uninsured will improve the full range of vertical health care services currently being provided and reduce inappropriate hospital admissions.

For more information on this program, please contact Seema Verma at (317) 221-2309 or email her at sverma@hhcorp.org.

LOUISIANA

Louisiana Public Health Institute

New Orleans' CAP grantee, Louisiana Public Health Institute (LPHI) is improving continuity of care and access to care by implementing an electronic interface linking the Medical Center of Louisiana with two community health centers, and Daughters of Charity Health Center. Using CAP funds, an affiliation agreement between the hospital and the two health centers was reached in which LPHI purchased software and hired an analyst to develop software that has enabled the clinics to share diagnostic information, patient histories, and emergency discharge reports with the hospital.

LPHI plans to create care coordination programs, grant medical staff privileges for clinic physicians to provide care at the hospital, and establish risk management protocols for high-risk patients. The care coordination programs will encourage maintenance of the relationship between patient and the primary care provider relationship. Moreover, LPHI is considering granting medical staff privileges so that physicians from the clinic can provide patient care at the hospital. In addition, LPHI is hiring a care coordinator to examine high-risk patients to determine how to improve care in order to reduce the number of subsequent visits for these patients. These initiatives are increasing the continuity of care for New Orleans residents.

For more information about this program, please contact Anne Witmer at (504) 539-9481 x 102 or email her at awitmer@lphi.org.

MASSACHUSETTS

Boston Medical Center (BMC)

Boston Medical Center's, CAP funding is being used to improve continuity of care by purchasing web-based data services that will allow them to access secure data from ten community health centers and a major teaching hospital via the internet, in order to follow patients across episodes of care. This Web-based reporting and analysis tool will enable the grantee to turn data into meaningful information that can be used to improve and increase the continuity of care for uninsured patients. This data reporting system would not be available without the CAP funding. Prior to the CAP grant, the parties did not have access to sufficient data to manage care across different sites. Furthermore, using this data tool will be a model for other state agencies and hospitals.

The software will enable hospitals and community health centers to share patient information and produce reports that can be used to track and better manage patient care for the 75,000 uninsured individuals who are registered in the BMC CareNet Plan (a program for the uninsured in Massachusetts). Clinical work groups will use this data to track episodes of care and develop intensive disease management and case management programs that will improve the access, quality and continuity of care. For example, this data will be used to help manage asthma care and monitor medication compliance. This should result in reduced use of the emergency department by asthma patients.

For more information on this program, please contact John Cragin at (617) 414-5117 or email him at john.cragin@bmc.org.

Cambridge Health Alliance

The CAP grantee in Cambridge, Massachusetts, launched in March of 2001, set a target of enrolling at least 50,000 of the community's 57,000 uninsured in a comprehensive, coordinated system of care by year four of the project, building upon a relationship between the Cambridge Health Alliance and more than 50 community partners. Other goals include enhancing preventive and early intervention services, enhancing care coordination, and implementing a shared database and care system to facilitate enrollment and case management. The collaborators agree that the level of cooperation and coordination among them would not have occurred without the seed funding provided through CAP.

For more information on this program, please contact Linda Cundiff at (617) 591-6930 or email her at lcundiff@challiance.org.

MINNESOTA

Hennepin County Medical Center

The Community Lifeline Project of Hennepin County, Minnesota, is using some of its CAP funding to provide community-based person-to-person support in navigating the health delivery system for the uninsured. For example, they have:

- enhanced a multi-lingual health information and referral phone line that fielded 1,491 calls in the first quarter of 2001 alone;
- hired 1 community health educator and 8 community health workers to assist 2,208 individuals apply for available public insurance programs;
- arranged for transportation to clinic appointments for 114 patients who might otherwise have been "no-shows" (the number of monthly rides increased more than threefold in the first three months of the year)
- placed community health workers at the county hospital emergency room and in community clinics to provide health education and information on appropriate use of emergency services; and
- held 15 community based health education fairs to further enhance outreach to the community.

For more information about this program, please contact Luann Nyberg at (763) 593-7709 or email her at luanne.nyberg@co.hennepin.mn.us.

MISSOURI

Kansas City Care Network

Truman Medical Center and the Kansas City Care Network are using their CAP grant to implement technological advancements in their health system. Partnering with Community Resource Network (CRN), Kansas City CareNet aims to provide shared software and computer connectivity between health care providers servicing the uninsured and underinsured in the Kansas City area.

By providing electronic connectivity, the CAP grantee's goal is to link local health-related and social service agencies through web hosting and inter/intranet tech-

nology in order to create a comprehensive database of health and social service information. Providers will then be able to access data to better serve their clients and offer the community a more seamless safety net system. This technology is providing the KC CareLink patients with an improved referral process and better overall coordinated care.

In a short time, KC CareNet has already organized information technology (IT) work groups, and completed the initial assessment of participating organizations' technology capabilities. KC CareNet has also recruited a Community Advisory Board, which oversees this project. Furthermore, staff members are researching local and national sources on HIPAA in order to be compliant when implementing this new technology.

For more information on this program, please contact Linda Davis at (816) 513-6348 or email her at Linda L Davis@kcmo.org.

NEW YORK

New York City Health and Hospitals Corporation (NYCHHC)

Within New York City and its five boroughs, New York City Health and Hospitals Corporation uses its CAP grant to achieve three goals: (1) improve birth outcomes in target communities, (2) facilitate and increase access to comprehensive clinical services, and (3) enhance community health education and outreach.

In a short time, NYCHHC is witnessing the results of their first objective through the "Sister Friend" program where high-risk expectant mothers are matched with mentors during their pregnancy. As of June, the program had enrolled over 20 participants per site in the program. Of those enrolled, five high risk mothers have delivered full term healthy babies. Furthermore, the program focuses on the mental health needs of their program members. For example, one woman in the program miscarried and remained in the program to undergo treatment for depression. A future goal of the program is to establish mental health screening for expectant mothers.

To meet their second objective, CAP funds will support a telephonic dial-up network to transmit specialty care referrals between 8 healthcare sites and HHC hospitals. Over the course of the year, they anticipate that this automated system will manage 4,800 referrals. This service will increase continuity of care, decrease missed appointments and reduce ER visits.

To meet their third objective, NYCHHC is conducting educational activities and forums for diverse patient groups to inform them how to enroll and obtain health care services. Sessions about the US health care system, Child Health and Family Health Plus programs, advance directives and end of life issues have been conducted for Asian Americans, Eastern Europeans, and Russian immigrants. By hiring educators from the same cultural background as these communities, NYCHHC believes that these individuals have been able to better maneuver the health care system. This has resulted in more people enrolling in health programs and using more appropriate levels of care.

For more information on this program, please contact Nina Sporn at (212) 788-3604 or email her at spornn@nychcc.org.

TENNESSEE

Erlanger Health System

Servicing residents living in Hamilton County, Tennessee, and its surrounding service area of eight southeast Tennessee counties, three northwest Georgia counties, and one northeast Alabama county, Erlanger Health System is using its CAP funding to achieve two main goals: improving access to primary care physicians to decrease emergency room usage, and increasing prevention initiatives within the community to lower avoidable health problems. To achieve the first objective, Erlanger hired three community health representatives who are focusing on different ethnic groups. By building relationships with local community organizations, churches and community centers, these community health representatives are facilitating several programs to educate individuals about healthcare issues such as utilizing health screenings, how to access services when needed, and how to complete healthcare forms. Other duties of the health representatives include managing client information, reminding patients of their medical appointments, documenting medical histories, making follow-up calls, and arranging transportation. Through the representative's guidance, patients learn to use their primary care physicians on a regular basis instead of the emergency room.

To address their second goal, Erlanger Health Systems is collaborating with other organizations such as the Homeless Coalition, First Call for Help, and Hamilton County Health Department to help educate citizens about healthcare issues. For ex-

ample, Erlanger and Hamilton County Health Department are working together to increase preventive care for adults by offering immunizations for parents and children at the beginning of the school year. Another notable example is Erlanger, City of Chattanooga and Hamilton County Parks and Recreation Departments are sponsoring exercise programs with the community to promote healthy lifestyles, which may prevent health problems later in life such as heart disease. Moreover, by increasing the number of preventive health opportunities, collaborations between organizations will prove to be beneficial to the local healthcare providers as well as the entire community.

For more information about this program, please contact George Ricks at (423) 778-2718 ricksge@erlanger.com.

Regional Medical Center at Memphis/Shelby County Health

As part of its CAP grant, The Memphis Community Access Program will implement a new system for referring uninsured patients seeking non-emergent care in the emergency room to primary care providers participating in the coalition. Prior to implementing the referral and appointment system, however, the grantee has conducted a rigorous evaluation of the cultural competency of the participating providers, to design a training program that can be specifically tailored to the cultural needs of the nonwhite uninsured populations in different areas of the city.

For more information about this program, please contact Brenda Theus at (901) 545-8565 or email her at Btheus@the-med.org.

TEXAS

The El Paso Hospital District/R.E. Thomason General

Using CAP funding, The El Paso Hospital District plans to decrease emergency room visits and increase enrollment in existing publicly funded programs. They are meeting these objectives by implementing a 24-hour Community Call Center, expanding the role of community health workers, and establishing a web-based information system.

Open to all El Paso County residents, the community call center answers medically related questions, refers social services calls to community health workers, and facilitates enrollment into existing programs. Using CAP funding, this grantee hired three nurses, five community healthcare workers, and one call center coordinator, all of whom are fluent in Spanish, to staff the call center. During the first month of operations, the center received almost 500 calls, of which approximately half were clinically related and half were for social services. For the medical calls, triage nurses recommend a course of care by following nationally certified adult and pediatric protocols. Using these care procedures, the triage nurses have reduced inappropriate emergency room use.

When social service calls are received, they are referred to community health workers, known as "promotoras." Promotoras perform a variety of tasks including promotion of preventive services and conducting community outreach. Furthermore, these community health workers make referrals to other state agencies for individuals and families to gain more information on programs such as WIC, SSI, and subsidized housing. Similarly, the community health workers help enroll individuals into programs like Medicaid.

Currently, El Paso County Hospital District, and other community partners, including community health centers, are collaborating on the development of a web-based information system to connect providers from with health community workers by allowing them access to health documents and demographical information. By expanding the role of the promotoras, these health workers can serve to facilitate issues related to health care and management, such as case management. The community health workers will also be able to identify which patients meet eligibility requirements of existing programs.

For more information on this program, please contact Mary Helen Mays at (915) 545-4810 or email her at mhmays@elp.rr.com.

Harris County Public Health And Environmental Services

In Harris County Texas, after one month of operation, the CAP coalition is already improving care for uninsured pregnant women. For example, prior to receiving CAP funding they organized and trained 22 volunteer Community Health Workers to act as liaisons with people in one of their communities to provide health education, information about available resources and a link into the health care delivery system which was previously unavailable. During the first month after receiving funding, just one of these workers reported that she had worked with 50 clients to facilitate access to care, including arranging for quicker prenatal care, identifying patients with serious complications that needed immediate attention, facilitating en-

rollment in various programs for health and social services, and generally navigating an otherwise perplexing and complex system of care.

For more information on this program, please contact Ron Cookston at (281) 447-2800 or email him at rcookston@hd.co.harris.tx.us.

The University of Texas Medical Branch at Galveston

In Galveston, Texas, a safety net coalition project known as "The Jesse Tree" has been able to leverage its federal CAP funding to greatly enhance its access to private charitable donations. The project now enjoys the support of well over 100 private organizations and individuals, whose contributions enable the project to substantially extend the reach of the federal grant dollars. This fundraising effort would not have been possible without the credibility and feasibility seeded through the CAP grant.

For more information on this program, please contact Ben Raimer, MD at (409) 772-5033 or email him at bgraimer@utmb.edu.

Mr. GREEN. I would also like to point out that the Institute of Medicine, the IOM, one of the most prestigious health research organizations in the country, has recommended the creation of a new Federal initiative similar to the CAP program to help improve coordination and communication among safety net providers. And the IOM recommends a minimum funding of $2.5 billion over 5 years.

Mr. Chairman, as the title of this IOM report indicates, our health care safety net is intact, but it is in trouble, and it is imperative we reauthorize or authorize the CAP program so we can strengthen our safety net and ensure that various health care providers work together to improve the health care of uninsured and underinsured Americans.

In closing, Mr. Chairman, I would like to compliment the hard work of my colleague and deskmate, Ms. Capps, on her effort in addressing the nursing shortage. I know in every urban area and I know in rural areas we have that problem. The nursing workforce is experiencing increasing staffing shortages and a decline in the recruitment of registered nurses. With the average Registered Nurse being 45 years old, and the aging of the Baby Boom generation, this nursing shortage could seriously diminish patient care, and I am a strong supporter of Ms. Capps' Nurse Reinvestment Act.

Mr. Chairman, with that, I yield back my time.

Mr. BILIRAKIS. I thank the gentleman. Mr. Pallone, for an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman, for holding this important hearing on safety net health programs. There is no doubt that we must do everything we can to protect Community Health Centers and other safety net public health programs in order to help continue their long tradition and mission of providing care to all, especially the underserved.

Although the President has included in his budget an increase for Community Health Centers, we must keep in mind that the number of uninsured patients treated by Health Centers is on the rise, and we must do everything possible to ensure the dependability of Health Centers to those who rely on them for health care services.

In this discussion of Health Centers, Mr. Chairman, I would like to bring up the issue of urban Indian programs. I have met with the National Council of Urban Indian Health, whose programs serve health care and referral services to approximately 332,000 urban Indians across 34 cities. The number of American Indians

living in urban areas is rising dramatically and, accordingly, the services provided by the Urban Health Centers become increasingly important to the urban Indian community.

The urban Indian population has a history and continues to suffer from health problems such as diabetes, obesity, poor nutrition, substance abuse, and many other problems that have devastating consequences. This stems from the fact that health care services are substandard and health education is not at its best.

The health status of American Indians requires special resources and, accordingly, I would like to see a portion of Section 330 funding go directly to Urban Indian Health Centers for the purpose of addressing these community-specific needs.

Now, I know that we will be hearing from Bob Hall, who is President of the National Council of Urban Indian Health, and I know he will be expanding on the health issues of particular importance to urban American Indians. I hope my colleagues will learn about and appreciate the need for extra resources for the urban American Indian community, and that we can continue with debate and action on this very important issue. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman and, without objection, the opening statement of all members of the subcommittee will be made a part of the record.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, ENERGY AND COMMERCE COMMITTEE

First, let me thank Subcommittee Chairman Bilirakis for holding this legislative hearing today. I commend him for putting together what promise to be two very informative panels of witnesses, who will discuss several crucial issues related to public health safety-net programs. These programs are vital to our efforts to provide care for those most in need in this country.

As we consider these issues, we should bear in mind that there are many uninsured Americans who need good health care, but have a difficult time finding it. Part of the problem is that America doesn't have enough people like Dr. Gary Wiltz of the Teche Action Clinic, in Franklin, Louisiana.

Dr. Wiltz, who will testify on the first panel, is a very fine Louisianan who has chosen to devote his life and practice to serving others less fortunate than himself in underserved areas in the state. I note that he first came to the Teche Action Clinic, a Federally-recognized Community Health Center, through the National Health Service Corps.

I'm interested in learning more about what we can do to encourage more health care providers, who share a sense of duty and mission to the poor, to do what Dr. Wiltz is doing and practice medicine in underserved areas.

Now, by definition, underserved areas lack health care providers because few providers are attracted to these areas in the first place. One solution that we will examine today involves expanding care in these areas by encouraging more faith-based charities to provide health care services to the poor. Already, faith-based charities have been credentialed by the Federal government and receive funding through the Community Health Center program.

We also need to examine the broader workforce challenges surrounding the recruitment of sufficient candidates for service in the National Health Service Corps. This program has done a great deal to address the shortage of health care professionals in undreserved rural and urban areas. Yet more must be done. Currently, there are more than 14,000 areas in this country that Federal officials designate as having a shortage of health professionals.

We need to discover whether or not difficulty in attracting candidates to serve in the National Health Service Corps is compounded by the problems of shortages in certain health professions in general. What can we do to encourage more people to become nurses, medical technologists, or pharmacists?

Mr. Chairman, I look forward to learning more about these challenging issues from our witnesses, and thank you again for bringing these matters into focus.

PREPARED STATEMENT OF HON. ED TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

I believe that this hearing is critical to enhancing access for the uninsured and to address the workforce shortage problems experienced by many of our health professionals.

Both the community health centers and the National Health Service Corps have played a critical role in providing care to the medically underserved. I am hopeful that this committee will maintain its traditional support for the centers and mid-level practitioners. I am particularly concerned about future legislative proposals, which would impact nurse clinicians and physician assistants. These health providers continue to be the backbone of our national primary health care system. While many competing interests have suggested that we eliminate the 10% set-aside for these providers in the Service Corps' reauthorization bill, I want to stress that it is important that we continue to support resources for the development of primary care providers. Without the current set-aside, historically mid-level practitioners simply did not receive corps loans and scholarships.

On the question of workforce shortages, I am hopeful that the committee's action will reflect the needs of all aspects of the health care systems. For example, hospitals, nursing homes, home health agencies and many other entities are all reporting a nursing shortage but they also all have differing needs as to what kind of personnel shortage they are experiencing. Additionally, we need to ensure that workforce proposals also will ensure the diversity that our country will need in the 21st century to service the multi-lingual and multi-cultural country that the U.S. has become.

I look forward to working with you Mr. Chairman and the members of this subcommittee on addressing the challenges presented by the concerns of our safety net providers.

PREPARED STATEMENT OF HON. ELIOT ENGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, Ranking Member Brown, I want to thank you for having this hearing today. I am pleased that the Committee is discussing issues such as the health care workforce shortage, the status of our nation's health centers, hospitals, and other safety net providers. These are matters of tremendous importance that tend to get overshadowed in the face of higher profile issues, such as Medicare reform and a prescription drug benefit. So again, I am pleased that we are giving the proper attention to these issues.

Our health care workforce is currently under tremendous strain due to worker shortages in a number of areas. Areas that have been hit the hardest are the nursing workforce, health aides, and pharmacists. While all of these are a matter of great concern, I am particularly sensitive to the nursing shortage. Nurses are the backbone of our health care delivery system in every aspect of care. Nurses are on the front lines in our hospitals, nursing homes, physician offices, and home care agencies, and we are experiencing shortages in all of these areas. For Congress to sit idly by while this problem worsens is an injustice to the nursing profession, health care facilities, and especially our patients who rely on nurses every day.

GAO Director William Scanlon has testified before Congress that the nursing shortage is real, it is likely to get worse, and it is due to a number of factors, including an aging workforce, fewer nurses entering the field, and job dissatisfaction. I believe that he is correct and that we in Congress must act to address this problem. To that end, I have been in contact with nursing associations, hospital associations, nursing homes, and home care agencies in New York and nation-wide to determine what could be done to alleviate the situation. In those discussions several dynamics of the problem have been identified, such as fewer teachers to teach new nurses, fewer students entering into nursing schools, an increasing number of nurses leaving the field for more lucrative careers or because they are dissatisfied with their jobs.

In response, I developed HR 1897, the Nurse of Tomorrow Act, which has bipartisan support, including Ms. Bono who has worked with me on this issue. The Nurse of Tomorrow Act is a multi-faceted approach to this complex problem. HR 1897 is designed to create educational and economic incentives in an effort to recruit and retain more nurses. The legislation provides for grants to health care facilities for nurses to continue their education and grants to nursing schools to reinvest in their programs so that they can recruit more youth into the nursing field. It also creates economic incentives for nurses by allowing a $2000 tax credit, along with increased loan forgiveness funding. I have received letters of support from the American

Nurses Association, the American Hospital Association, and other groups in New York and nation-wide, which illustrate the importance of this issue.

I have also cosponsored HR 1436, the Nurse Reinvestment Act, introduced by Ms. Capps. I believe that this issue requires us to take action. I hope this Congress will take heed and pass legislation to alleviate the nursing shortage and other areas of need. Mr. Chairman, I thank the witnesses for their time and look forward to their testimony on the issues before the Committee today.

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I thank you for holding this hearing today. The programs that we will discuss make up a large part of what is commonly referred to as the health care safety net. We aspire to make quality health care available to all through affordable insurance, but we know that there will always be a need for public health programs that directly provide health care to millions of needy citizens. And when times are the toughest, they're needed the most. As the economy continues to cool after eight years of unprecedented growth and prosperity, many Americans find themselves out of work or in low paying jobs, putting health insurance for themselves and their families out of reach.

The community health centers, National Health Service Corps, and allied health professions programs for nurses all have proven track records of outstanding service and effectiveness. But they face many challenges. First among these is resources. The Bush Administration's budget calls for an increase in Community Health Centers (CHC) funding, but that increase is inadequate to close the gap between the number of persons who need the services of CHCs and those who receive them. Other safety net programs have been slated for cuts, elimination, or inadequate increases. One of these, the Community Access Program, is quite popular among safety net providers and should be restored, if not increased.

The National Health Service Corps and the Title VI II health professions programs for nurses serve an absolutely essential role of providing personnel to medically under served areas. I intend to focus on the present and future needs of these programs and will carefully scrutinize any proposals aimed at fundamentally altering their structure. While I understand the Administration's desire for "flexibility," what will that mean for the needs these programs meet?

I look forward to working with all of my colleagues to build a public health safety net that is stronger than ever.

Thank you.

PREPARED STATEMENT OF HON. JOHN SHIMKUS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Thank you, Mr. Chairman, for holding this hearing on public health issues.

Dr. Cory Roberts is testifying today regarding the shortage of non-physician medical laboratory personnel. Due to growing concern from my constituents, I have introduced legislation that addresses this alarming shortage and would like to take this opportunity to discuss the issue further.

The vital role medical laboratory professionals play in health care must not be taken lightly. It is estimated that approximately 70-75 percent of all medical diagnoses are performed by the laboratory. Yet, since these professionals often work "behind the scenes," few people know much about the critically important testing that laboratorians perform every day. Laboratory personnel are often used in preventative medicine: to detect diseases early, rule out incorrect diagnoses, and to insure that a chosen treatment is working.

It is imperative that we work now to address this shortage, and bring needed professionals into the laboratory field.

Vacancy rates for cytotechnologists (the professionals who interpret cellular material such as Pap smears) and histotechnologists (the individuals who prepare tissue specimens for cancer biopsies) are at a startling high of over 20%, according to the American Society of Clinical Pathologists. Shortages are also increasing for other laboratory positions, such as medical technologists and medical laboratory technicians.

To make matters worse, the number of accredited educational programs for laboratory medicine positions has decreased significantly over the past two decades with schools closing in several states. We need to act now to reverse this trend.

The legislation I have introduced along with Mr. Jackson, Chairman Bilirakis, and the distinguished Ranking Member, Mr. Brown, addresses this critical shortage.

HR 1948, the "Medical Laboratory Personnel Shortage Act" expands existing federal programs with a focus on laboratory personnel needs.

The bill includes provisions to expand the eligibility for the National Health Service Corps to include medical laboratory personnel, and expand programs for increasing medical laboratory personnel in the areas of cervical cancer screening, antimicrobial resistance efforts, bioterrorism, and transfusion medicine. It also increases funding for the Allied Health Project Grants program, which helps attract laboratory professionals to the field—especially minorities and individuals in rural and underserved communities.

I urge my colleagues to recognize the nationwide shortage of medicallaboratory personnel, and join with me in supporting this importantlegislation.

Thank you, Mr. Chairman, for the opportunity to speak on this issue.

Mr. BILIRAKIS. We will now go into the first panel. Dr. Elizabeth James Duke is the Acting Director of the Health Resources and Service Administration; Dr. Gary Wiltz is with Teche Action Clinic, Franklin, Louisiana—I know the chairman wanted to be here, sir, to personally introduce you, but the energy bill is on the floor and, as you know, we have principal responsibility over that, and that is the only reason he isn't here. He will probably come walking in sometime. Ms. Kathryn S. Benjamin, Executive Director of the Southeast Lancaster Health Services, out of Lancaster, Pennsylvania; Dave Brewton, Director of Development, East Liberty Family Health Center, Pittsburgh, Pennsylvania—I am a former Pittsburgher, Mr. Brewton, and went to Pitt, so I know that area somewhat—Jeff Singer, President and CEO of the Health Care for the Homeless, Baltimore, Maryland; The Honorable Angela Monson, Oklahoma State Senate, Vice President of the National Conference of State Legislatures—welcome, Ms. Monson; and Bob Hall, President of the National Council of Urban Indian Health.

Ladies and gentlemen, I am not sure I know, with the limited period of time, how many of you submitted a written statement to us, but in any case it is a part of the record, and we would hope that you would complement it and supplement it. I will set the clock at 5 minutes. I won't cut you off, but hopefully you can keep your statement to as close to 5 minutes as possible.

Dr. Duke, we will start off with you. Please proceed, ma'am.

STATEMENTS OF BETTY JAMES DUKE, ACTING DIRECTOR, HEALTH RESOURCES AND SERVICE ADMINISTRATION; GARY MICHAEL WILTZ, TECHE ACTION CLINIC; KATHRYN BENJAMIN, EXECUTIVE DIRECTOR, SOUTHEAST LANCASTER HEALTH SERVICES; DAVID BREWTON, DIRECTOR OF DEVELOPMENT, EAST LIBERTY FAMILY HEALTH CENTER; JEFF SINGER, PRESIDENT & CEO, HEALTH CARE FOR THE HOMELESS; HON. ANGELA MONSON, OKLAHOMA STATE SENATE AND VICE PRESIDENT, NATIONAL CONFERENCE OF STATE LEGISLATURES; AND ROBERT HALL, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

Ms. DUKE. Thank you very much, sir. I have submitted a statement for the record. I will summarize and will stay within your time line.

Mr. Chairman and members of the committee, thank you very much for the opportunity to speak to you today about health care in America.

The Health Resources and Services Administration, otherwise known as HRSA, is committed to working toward 100 percent ac-

cess to health care and zero health disparities for all Americans. To achieve this goal, HRSA works closely with State and local governments and organizations to build a foundation for a national safety net of health care services that promote the health and well-being of our Nation's most vulnerable individuals and families.

Under the leadership of President Bush and Secretary Thompson, HRSA is prepared to reinforce and expand the health care safety net to reach more vulnerable Americans who are in need of primary health care services. The administration's commitment is evident in its fiscal year 2002 financial support for the cornerstone of HRSA's safety net programs, the Community Health Centers.

As the foundation for health care safety nets in more than 3200 communities nationwide, community health centers deliver family oriented preventive and primary health care services to approximately 10.5 million people who live in medically underserved areas in rural and urban communities.

The President's 2002 Budget request includes nearly $1.3 billion for Community Health Centers, an increase of $124 million above the fiscal year 2001 appropriation. Funding at this level will allow health centers to increase the number of existing and expanded health care access points by 200 in 2002, providing services for up to 1 million additional people, including 460,000 uninsured people. This increase is the first installment of a multi-year initiative to increase or expand health center access points by 1200 by the year 2006 and eventually double the number of people served.

Through the President's Community Health Centers Initiative, new grantees will address health care problems they encounter in their communities. We will see small health centers grow to meet the increasing needs and demands for their services, and we will see mid-size centers grow into large-scale operations as these additional resources provide them with the chance to serve even more of the medical needs for a growing and aging population.

Community Health Centers serve our most vulnerable populations. In collaboration with State and local community partners, HRSA's Community Health Centers are an indispensable component of the national health care safety net.

The National Health Service Corps has been a critical element in the safety net for over 25 years. Since 1972, the National Health Service Corps, through its scholarship and loan repayment programs, has placed over 22,000 health care clinicians in a health care shortage area. Today, 2500 clinicians serve in border towns, rural areas, inner cities, in every State, the District of Columbia, Puerto Rico, and the Pacific Basin.

The 2002 budget launched a Presidential Management Reform Initiative for the National Health Service Corps so it will better be able to address the neediest communities. We are examining the ratio of scholarships to loan repayments, to ensure maximum flexibility in placing of National Health Service providers. We will also seek to amend the professional shortage area definition to reflect other non-physician providers practicing in communities, which will enable the Corps to more closely and accurately define shortage areas and target their placements better. To further avoid overlap in the provision of health care, HHS has begun its coordination with immigration programs, including the J-1 and H-1C

visa programs which review applications for health care providers practicing in underserved communities.

These reform proposals will build on the existing success of the Corps and in turn strengthen the national safety net since many providers spend all or part of their careers serving where others choose not to go.

HRSA remains sensitive to the needs of America's rural populations, who often lack ready access to health care providers. HRSA's Office of Rural Health Policy coordinates rural health policy issues within the Department of Health and Human Services and is the Department's focal point for coordinating public and private sector efforts to strengthen and improve the delivery of health services to populations in rural areas nationwide.

Bringing health care to rural areas means creating and building medical infrastructure and allowing patients to heal in their own communities. We know that patients tend to do better when they are treated closer to home. Friends and family can visit and offer support and encouragement, and knowing that the physician lives in your community, that he sees the same things that you do, and that she is an active participant in the school, increases confidence, and cultural competence.

Also to increase the strength of the safety net we will look to more tightly weave telehealth into areas where physicians do not have the experience in treating specific diseases. Since 1988, our growing telehealth network continues to provide increasing access to health care expertise to emerging communities and rural areas.

Sir, I will reserve the rest of my statement.

Mr. BILIRAKIS. You are welcome to summarize, if you would like.

Ms. DUKE. Basically, we are here to talk about two programs that have had very successful history and which we seek to expand and to strengthen. Thank you.

[The prepared statement of Betty James Duke follows:]

PREPARED STATEMENT OF BETTY JAMES DUKE, ACTING ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman, Members of the Subcommittee, thank you for the opportunity to speak to you today about health care in America. I am Betty James Duke, Acting Administrator at the Health Resources and Services Administration, an agency within the Department of Health and Human Services.

The Health Resources and Services Administration, otherwise known as HRSA, is committed to working toward 100 percent access and zero disparities. To achieve this goal, HRSA works closely with State and local governments and organizations to build a foundation for a national safety net of health care services that promote the health and well-being of our nation's most vulnerable individuals and families.

Under the leadership of President Bush and Secretary Thompson, HRSA is prepared to reinforce and expand the health care safety net to reach more vulnerable Americans who are in need of primary health care services. The Administration's commitment is evident in its FY 2002 financial support for the cornerstone of HRSA's safety net programs B the Community Health Centers.

COMMUNITY HEALTH CENTERS

As the foundation for health care safety nets in more than 3,200 communities nationwide, community health centers deliver family-oriented preventive and primary health care services to approximately 10.5 million people who live in medically underserved rural and urban communities.

The President's FY 2002 Budget request includes nearly $1.3 billion for Community Health Centers, an increase of $124 million above the FY 2001 appropriation. Funding at this level will allow health centers to increase the number of existing

and expanded health care access points by 200, providing services for up to one million additional people, including 460,000 uninsured. This increase is the first installment of a multi-year initiative to increase or expand health center access points by 1,200 by FY 2006 and eventually double the number of people served.

Through the President's Community Health Center Initiative, new grantees will address the health care problems that they encounter in their community. We will see small health centers grow to meet the increasing needs and demands for their services. And we will see mid-size grantees grow into large-scale operations as these additional resources provide them the chance to serve even more of the medical needs for a growing and aging population.

Community Health Centers serve our most vulnerable populations. The Health Center patient population consists of approximately:

- 86 percent below 200 percent of poverty;
- 40 percent uninsured (Health Center uninsured patients have increased at twice the national rate since 1990);
- 31 percent Medicaid recipients;
- 64 percent minorities;
- 40 percent children; and
- 30 percent women of child-bearing age.

Health Centers serve one in every six low income children, one in every 10 low income uninsured individuals, one in every 8 Medicaid recipients, one in every 4 homeless persons, one in every 5 migrant farm workers, and one in every 12 rural residents. The homeless community is particularly in need of health services—nearly 550,000 homeless patients (75 percent of whom are uninsured) are served through culturally competent clinicians. Also, nearly 600,000 patients of Health Centers are migrant-farm workers.

In calendar year 1999, health centers provided a full range of culturally competent primary and preventive health services over 36.6 million encounters. These services included:

- more than 270,000 HIV tests and counseling;
- over 900,000 pap smears;
- almost two million immunizations; and
- perinatal and delivery care for 137,000 women.

Health Centers have demonstrated their effectiveness by:

- improved health outcomes;
- increased preventive services;
- improved management of chronic diseases;
- reduced avoidable hospitalizations; and
- high patient satisfaction.

In collaboration with state and local community partners, HRSA's community health centers are an indispensable component of the national health care safety net.

NATIONAL HEALTH SERVICE CORPS

Health care at many community health centers is provided by medical professionals serving in HRSA's National Health Service Corps (NHSC). The NHSC has been a critical element in local safety nets for over 25 years. Since 1972, the National Health Service Corps, through its scholarship and loan repayment programs, has placed over 22,000 healthcare clinicians in areas with a health professional shortage. Today, 2,500 NHSC clinicians serve in border towns, rural areas, and inner cities, in every State, the District of Columbia, Puerto Rico, and the Pacific Basin.

The FY 2002 Budget launched a Presidential Management Reform Initiative for the National Health Service Corps so it will be better able to address the neediest communities. We are examining the ratio of scholarships to loan repayments, as well as other set-asides, to ensure maximum flexibility in placing NHSC providers. We will also seek to amend the Health Professional Shortage Area definition to reflect other non-physician providers practicing in communities, which will enable the NHSC to more accurately define shortage areas and target placements better. To further avoid overlap in the provision of health care, HHS has begun its coordination with immigration programs, including the J-1 and H-1C visa programs, which review applications for health care providers practicing in underserved communities.

These reform proposals will build on the existing success of the NHSC and in turn strengthen the national safety net since many NHSC providers spend all or part of their careers serving where others choose not to go. The NHSC has had remarkable success in placing its providers:

- approximately 97 percent of NHSC clinicians fulfill their service commitments;
- approximately 60 percent of NHSC alumni continue to serve the underserved four years after the completion of their service obligation, and 52 percent of NHSC alumni continue to serve the underserved 15 years after the completion of their service obligation;
- NHSC clinicians include significantly higher percentages of underrepresented minorities than the nation's workforce, and 53 percent of the patients who receive care from NHSC clinicians are minorities; and
- NHSC clinicians provide care to millions of Americans in community health centers, hospital clinics, county health departments, and Indian health clinics.

RURAL HEALTH AND TELEHEALTH

HRSA remains sensitive to the needs of America's rural populations, who often lack ready access to health care providers. HRSA's Office of Rural Health Policy coordinates rural health policy issues within the HHS and is the Department's focal point for coordinating public- and private-sector efforts to strengthen and improve the delivery of health services to populations in rural areas nationwide.

HRSA's Rural Health Outreach grants emphasize health care service delivery through creative strategies that require each grantee to form a network with at least two additional partners. By developing new health care delivery systems, these grants have improved access to care for more than 2.9 million citizens in rural areas.

The Rural Health Network Development grants assist in developing organizational capacity in the rural health care sector through formal collaborative partnerships that involve shared resources. Through these grants, communities can acquire staff, technical experts, and other resources needed to build successful health care networks.

Bringing health care to rural areas means creating and building medical infrastructure and allowing patients to heal in their own communities. We know that patients tend to do better when they are treated closer to their homes. Friends and family can visit them, and show them their encouragement. And knowing that the physician lives in your home community, that he sees the same things that you do, and that she is an active participant in the school, increases confidence, and cultural competence.

Also to increase the strength of the safety net we will look to more tightly weave telehealth into areas where physicians do not have the experience in treating specific diseases. Since 1988, our growing telehealth network continues to provide increasing access to health care expertise to emerging communities and rural areas. As we link these offices using state-of-the-art equipment and advanced technology to expert centers of disease and sickness management, we are providing critical, lifesaving information to health care providers who would otherwise lack the specific expertise.

COMMUNITY ACCESS PROGRAM

As outlined in the President's FY 2002 Budget, the Administration proposes the elimination of the Community Access Program (CAP). After a careful review, the Administration concluded that further fragmenting the resources available to public health providers by establishing yet another funding stream was not the most effective or efficient way to improve health care access for the uninsured. Rather, the Administration believes we should invest in proven programs like Community Health Centers and Medicaid.

HRSA provides communities with access to existing funding resources that would enable them to pursue the same goals as CAP. For example, Community Health Center funding already supports an Integrated Service Delivery Initiative (ISDI), which provides funding to health centers to encourage them to integrate functions with other centers and safety net providers in their communities. In addition, in FY 2000, HRSA targeted $41 million of its funding increase for a Health Center investment process to fund existing health center grantees that demonstrate effectiveness at serving a disproportionate share of uninsured and under-insured patients.

As I mentioned in the beginning of my testimony, HRSA and the Administration are committed to ensuring access to basic, quality health care now and in the future. We have spent a great deal of time and effort to strengthen and streamline HRSA programs and services that will lead to a tighter, stronger health care safety net.

Mr. BILIRAKIS. Thank you, Dr. Duke.

Dr. Wiltz.

STATEMENT OF GARY MICHAEL WILTZ

Mr. WILTZ. Chairman Bilirakis, Ranking Member Brown, Ms. Capps and Mr. Pitts, I am Gary Wiltz. I am a Board-certified internal medicine physician and Clinical Director of the Teche Action Clinic, a federally supported health center in the rural bayou country of Louisiana. I appreciate the opportunity to speak to you on behalf of the National Service Corps and the National Association of Community Health Centers in caring for the uninsured and underserved people of this country.

To meet the challenge of the President and the Congress have set out in doubling the capacity of health centers to care for the uninsured, we ask that this subcommittee and Congress act without delay to reauthorize these programs and make needed changes to strengthen them.

I want to thank this subcommittee for the incredible support it has given health centers. Chairman Bilirakis and Ranking Member Brown, thank you for actively and enthusiastically leading the efforts of the House to increase funding over the last 4 years. I particularly want to thank my Representative, Chairman Tauzin, for the unwavering support he has given to our health center and all health centers.

I am here today to tell you about both of these programs and how they have had a profound impact on the health in our community, and that health centers around the country are ready to meet the challenge that we face. We have a 35-year-old commitment to quality health care that vulnerable populations can take to the bank.

In 1976, I was a first-year medical student at Tulane, and my only collateral in life were my dreams. I was fortunate enough to be selected to become a member of the National Service Corps, and after completing my training in 1982 I was assigned to Teche in Franklin. Looking over the last 19 years, I can see the fruits of our labor, a priceless gift in one's lifetime.

My experiences can best be reflected in a remark made by the daughter of one of my patients, who I had just seen through a life-threatening episode. She asked me how did I come to be in Franklin, and I responded that I came via the Corps. She responded, "I never heard of it, but thank God for the Corps." I also thank God for the Corps and for the health centers program, and the wonderful, often miraculous, effects they are having on the people across America. We stand ready, willing and able to meet the challenges of caring for the underserved, but to do so Health Centers request that this Subcommittee and the Congress help us in the following ways:

First, reauthorize and make key improvements to the health center program, including restoration of facility construction and expansion as allowable uses of funds. A recent survey found that almost two-thirds of health centers currently need to be upgraded, expanded, or replace their facilities.

Second, reauthorize and strengthen the National Health Service Corps program and streamline it to work more effectively with all safety net providers to improve health care access. The Corps has brought thousands of health care professionals to underserved areas over the past 30 years.

Third, continue your support to fulfill the long-range plan endorsed by the President and Congress to double the number of people served and a doubling of the Corps over the next 5 years, which will bring quality health care to more than 20 million individuals by the year 2006.

Finally, support the efforts of local safety net providers to better organize care for uninsured and underserved such as those funded under the new Community Access Program, taking care that these efforts complement existing Federal programs and include local safety net providers as Corps decisionmakers and grant recipients.

The success of health centers can be traced to the Corps elements of Section 330, which require that we be located in and serve medically underserved communities; ensure the proper targeting of Federal resources on areas of greatest need; make services available to all residents of the community with regard to ability to pay, with charges based on family income; provide comprehensive primary and preventive care services which improve both the accessibility and effectiveness of care; and be governed by a Board of Directors, the majority of whose members are active patients. Nowhere are these elements more deeply routed than at Teche where 51 percent of our Board is composed of everyday people who are interested in making the center a success.

Our president and several board members are also leaders in the local faith community. Our board also includes local business owners, educators, and government officials. The community board has viewed our compassion to provide care that is closely attuned to the values that reflect the spirit of our community.

In 1999, nearly 1,000 health centers served more than 11 million people in 3,200 communities across the country, including 1 of every 9 uninsured Americans, 1 of every 6 low-income children, 1 of every 10 rural Americans, and more than 7.5 million people of color, in addition to 600,000 farm workers, 600,000 homeless people. Last year, we provided 22,438 visits to 6,403 at our center, 46 percent of those patients were uninsured.

Health Centers are a God-send for communities in providing a patient-centered, culturally competent program with an interdisciplinary team of providers in one location. Our center boasts four Board-certified primary care physicians, a Physician Assistant, two dentists, two pharmacists, and a full complement of support staff that provide services 5-days-a-week and after-hours coverage.

Our newest physician, Dr. Tammy Mitchell, has dreams of establishing a preventive health program in area churches that will be linked to our center. They would monitor hypertension and diabetes, as well as conduct health education sessions to reduce morbidity stemming from poor diet and other lifestyle risk factors.

Health centers are subject to stringent Federal monitoring of their cost-effectiveness, quality of care and management. We provide quality comprehensive primary care to some of the hardest to reach patients in the health system at a price second to none. The average cost of health center services amounts to less than $350 annually, which is less than a dollar a day for each person served.

We also recognize the power of collaboration, and we have developed a coordinated health care delivery system network that is try-

ing to connect through the use of the Internet and telemedicine several centers of community providers across Bayou country.

I would like to take this opportunity to thank you for the opportunity to present our views and look forward to working with you to improve and expand health care access to the uninsured and underserved across the country.

[The prepared statement of Gary Michael Wiltz follows:]

PREPARED STATEMENT OF GARY MICHAEL WILTZ, CLINICAL DIRECTOR, TECHE ACTION CLINIC ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS

Chairman Bilirakis, Ranking Member Brown, and Members of this Subcommittee: My name is Gary Michael Wiltz. In 1976 I was a first year medical student at Tulane Medical School, at that time my only collateral in life was my dreams. In seeking to make those dreams a reality I was fortunate enough to be selected to become a member of the National Health Service Corps. It was through that relationship that I was assigned to Teche Action Clinic in Franklin, Louisiana in 1982. Nineteen years later I sit before you as a Board Certified Internal Medicine Physician and Clinical Director for the Teche Action Board, Inc. TAB as we refer to it, is the not for profit governing body of Teche Action Clinic, a federally-supported health center in rural south Louisiana, in St. Mary parish. St. Mary parish like most areas of Louisiana is rich both culturally and historically. For example the name of our health center reflects the Native American heritage in our community as in the term "Bayou Teche" which means a snake-like or winding river and the "Action" reflects the period in which our health center was born. We were incorporated in 1974 on the heels of the civil rights movement, which motivated us to take "action" on the needs of our community.

I appreciate the opportunity to speak with you today, on behalf of the National Association of Community Health Centers, about the work of health centers and the National Health Service Corps in caring for uninsured and underserved people in our country. I am here today to tell you that both of these programs have had a profound impact in helping our community in Louisiana take care of our health care needs, and to let you and the Congress know that we, and health centers around the country, are ready to meet the challenge the President and Congress have set for us: to double the capacity of health centers to care for the underserved over the next five years.

I want to thank this Subcommittee for the incredible support it has given health centers in carrying out their mission. Chairman Bilirakis and Ranking Member Brown, thank you for actively and enthusiastically leading the efforts of the House to increase funding for health centers over the last four years, as well as to establish a prospective payment system for health centers that will provide them a stable base when they care for Medicaid patients. Chairman Bilirakis, thank you also for leading the Health Center Caucus, with Representatives Danny Davis, Mike Capuano, and Henry Bonilla. I particularly want to thank my representative, Committee Chairman Billy Tauzin, for inviting me here today and for the unwavering support he has given to our health center and all of the health centers around the country.

My testimony today will focus on the following:

1. As my personal experience at our center demonstrates, health centers are doing the job expected of them by this Subcommittee and the Congress—providing quality health services at low cost for millions of low-income Americans.
2. The National Health Service Corps is a critical tool that has successfully brought thousands of health care professionals to underserved areas over the past 30 years.
3. Health centers need the continued support of this Subcommittee, and indeed of the entire Congress, in order to continue fulfilling the long-range plan endorsed by the President and the Congress to double the number of people served by health centers over the next 5 years, and a doubling of the NHSC is an integral part of this plan.
4. To meet this goal, health centers request that the Subcommittee and Congress act without delay to reauthorize the health centers program and the National Health Service Corps, and to make needed changes to strengthen the ability of these programs to care for the uninsured and underserved.

HEALTH CENTERS ARE HIGH QUALITY, COST-EFFECTIVE PROVIDERS

Health centers today represent more than 35 years of federal, state, and local community investment in primary care infrastructure for medically underserved people and communities. Most community, migrant, homeless and public housing health centers receive grants under section 330 of the Public Health Service (PHS) Act, which is authorized by this Subcommittee. Other community-based health centers are designated as Federally qualified health centers (FQHCs) under the Medicare and Medicaid laws because they meet all the requirements applicable to health centers that receive Federal grant assistance, but sufficient grant funds are not available to provide them with Federal support. These health centers have improved access to care and have reduced health care costs, while sustaining and enhancing the quality of care provided.

Health centers were established to provide access to quality preventive and primary health care for the medically underserved—including the millions of Americans without health insurance, low income working families, members of minority groups, rural residents, homeless persons, and agricultural farm workers. Since their inception, health centers have served as a prototype for effective public-private partnerships, demonstrating their ability to involve a wide range of community members to meet local health needs while being held accountable for meeting national performance standards.

The success of the health centers program is due in great part to the core elements found in Section 330 of the Public Health Service Act, its authorizing statute. These elements stipulate that each federally-supported health center must:

- Be located in, and serve, a community that is designated as "medically underserved," thus ensuring the proper targeting of federal resources on areas of greatest need.
- Make its services available to all residents of the community, without regard to ability to pay, and make those services affordable by discounting charges for otherwise uncovered care to low-income families in accordance with family income.
- Provide comprehensive primary health care services, including preventive care (such as regular check-ups and pap smears) and care for illness or injury, as well as services that improve both the accessibility of care (such as transportation and translation services) and the effectiveness of care (such as health/nutrition education).
- Be governed by a board of directors, a majority of whose members are active, registered patients of the health center, thus ensuring that the center is responsive to the health care needs of the community it serves.

51% of our Board of Directors is composed of everyday people in the community who are interested in making the center a success. Our Board President, as well as prior Board Leaders and Executive Committee members are also leaders in the local faith community. Our Board also includes local business owners, educators, and government officials. The community board has fueled our compassion and desire to provide care that is closely attuned to the values that reflect the spirit of our community.

Health centers have an impressive record of using the federal grant investment to care for underserved Americans. In 1999, nearly 1000 health centers served more than 11 million children and adults in 3200 communities across the country. More than 9 million people obtained care from health centers that receive funding from the federal health centers grant program, while another 2 million people received care from designated FQHCs that do not receive grant funds. Health center patients include:

- 4.6 million uninsured persons, 1 of every 9 uninsured Americans;
- 4.6 million children, 1 of every 6 low-income American children, including 1 of every 4 low-income uninsured children (1.6 million);
- 4 million children and adults with Medicaid or CHIP coverage, 1 of every 9 Medicaid/CHIP recipients;
- More than 7.5 million people of color, two-thirds of all health center patients;
- 5.4 million people living in rural communities, 1 of every 10 rural Americans;
- More than 600,000 agricultural farm workers; and
- More than 600,000 homeless persons.

Health centers are community owned and operated businesses—professional health care organizations providing a comprehensive range of high quality preventive and primary health care services under one roof, in a "one stop caring" system. We offer care, both for prevention and for treatment of illness or injury, and in addition provide diagnostic laboratory and x-ray services, as well as prescribed medications in many cases. In our center we have a substantial pharmacy program. Health

center clinicians make referrals to specialists and admit and follow their patients in the hospital, when necessary. Health centers provide continuous care to their patients, regardless of changes in their insurance coverage or their health status. Many of the medically underserved come from different cultures and have primary fluency in languages other than English. According to the Bureau of Primary Health Care, some 23 percent of all health center patients fit this description—and for them, health centers employ multilingual and multicultural providers or provide translators to ensure that the care provided is both clearly understood and culturally appropriate. I think that community health centers are a Godsend for communities because we provide a humanistic, culturally competent program with an inter-disciplinary team of providers. Our team consists of 4 board certified primary care physicians, 1 physician assistant, 2 dentists, and 2 pharmacists, with a full complement of support staff that provide services five days per week with after hours coverage.

Each local health center is unique in terms of the range of services it offers and its hours of operation, reflecting local decisions on how best to meet the health care needs of that health center's patients. At the same time, all of the health centers are subject to ongoing federal monitoring of their cost-effectiveness, quality of care, and management at a level which is more stringent than that applied to any other provider. And I'm pleased to report that, to date, more than 250 health centers—including ours—have received full accreditation from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)—an excellent, independent measure of the quality of their care.

The care that health centers provide is financed by a variety of sources. The federal health center grants provide, on average, about 28 percent of a health center's budget. Medicaid and CHIP payments account for about 38 percent percent, on average, of a health center's budget. State and local government support, and private donations, provide 14 percent of health center revenues nationally, while 7 percent comes from private insurance, and 6 percent from Medicare. Every health center patient contributes to the cost of his or her care, and on average, 7 percent of income comes from patient fees. These averages will vary for each health center, depending on the financing sources available to people in the local community. At Teche, our program budget has grown over the years from $250,000 when I started in 1982 with 8 staff to a $2.5 million dollar budget in 2000 with 41 staff. We provided 22,438 visits in 2000 to 6,403 patients. Forty-six percent of our patients are uninsured, and these patients pay on a sliding fee scale discount according to their household income and family size. Seventeen percent of our patients have Medicaid coverage; 21 percent, Medicare; and 16 percent, private insurance.

Health centers are one of the best health care and taxpayer bargains anywhere. The combination of locally responsive health care delivery and consistent federal oversight has proved to be a winning formula. Health centers provide comprehensive services to their patients at an astonishingly low cost. The average total cost of health center services amounts to less than $350 annually—less than $1 a day—for each person served.

As a community health center physician for the past nineteen years, I have experienced firsthand the immense value of this model of care for our patients. Everyday in our center we see hundreds of patients who are uninsured and are plagued with diseases that demand continuity of care. For example, one couple that I treat are on a combined fixed income of less than $10,000 per year, and both of them have the same medical problems—diabetes, hypertension, hyper-lipidemia, coronary artery disease, and osteo-arthritis. Together, they are on about 15 medications, the total cost of which would normally exceed their entire income. However, because of our special pharmacy program, this couple is able to avert the life threatening effects of uncontrolled disease.

Dozens of studies and reports show that health centers substantially improve the health of individuals in their communities and provide care in a highly cost-effective manner. The impacts health centers have had on the health of individuals in their communities include lower hospital admission rates, shorter lengths of stay and less inappropriate use of emergency room services, significantly lower infant mortality rates and reduced incidence of low birth weight, higher childhood immunization rates, and better use of preventive health services (like Pap smears, mammography, and glaucoma screening), resulting in lower rates of preventable illnesses.

Several studies over the last decade have found that Medicaid patients who regularly use health centers receive care of equal or greater quality and cost significantly less than those who use private primary care providers, such as HMOs, hospital outpatient units or private physicians. These findings are consistent with those from dozens of previous studies on the cost-effectiveness and quality of care provided through the health center model, and in particular documenting their sub-

stantial savings to state Medicaid programs. The record is clear that health centers provide quality, comprehensive primary care to some of the hardest-to-reach patients in the health system at a price second to none.

Health centers have joined with each other and with other local providers to form integrated service networks to coordinate and improve their purchasing power and/or to better organize the continuum of care, especially for those who are uninsured. These include practice management networks, designed to improve quality through shared expertise (such as centralized pharmaceutical or laboratory services, clinical outcomes management, or joint management/administrative services), to lower costs through shared services (such as unified financial or management information systems, or joint purchasing of services or supplies), or to improve access and availability of health care services provided by the health centers participating in the network. Today, nearly 400 health centers are involved in some 50-plus local networks across more than 35 states, each designed to lower costs and/or to improve care. Separately, some 250 or more health centers are participating in state-wide or regional collaboratives designed to significantly improve health care management for patients with chronic conditions like asthma, hypertension, diabetes, cardiovascular diseases, HIV infections, depression and environmental health conditions. In addition, health centers all across the country have taken steps to form networks with other local providers and to develop the financial, legal and business acumen necessary to function effectively in managed care. Almost three-fourths of all health centers are participating in managed care as subcontracting providers to managed care plans, serving more than 2 million managed care enrollees.

Our organization recognizes the importance and the power in collaboration. We work cooperatively with several organizations in our community, some of which receive federal grant support. We have formed the Bayou Teche Community Health Network and our collective vision is to build a coordinated delivery system that will reduce duplication of services and ultimately reduce the cost of care for the population in our respective service area. We want to do this by devising an information technology infrastructure that uses the power of the Internet and telemedicine technology to connect several essential community providers across Bayou country. These providers include local social service agencies that will be able to provide transportation and case management so as to complete or close the gaps in the present delivery system. We also want to use this framework to develop more community health centers that tie into a larger system of care. This is important because we recognize that as the Congress continues to support these programs it is imperative that they are sufficiently integrated into the larger systems to ensure their effectiveness and the quality of their care.

We also believe in collaborating with other community organizations. One of our newest physician staff members is Dr. Tammy Mitchell. I encountered this young lady's family early in my practice, as both of her parents are my patients. As soon as I learned of her interest in becoming a physician I can say proudly that I was able to do for her what my mentor Dr. Cherie Epps did for me as a medical school student at Tulane University. Today she is practicing as a Family Medicine Physician in our clinic. Her family also includes several strong ministerial leaders in our community. Her dream and desire is to establish preventive health programs in area churches that will be linked into our community health center. Her program would be modeled after the American Heart Association's "Search Your Heart" program which is a church-based heart and stroke prevention clinic. It would consist of monitoring hypertension and diabetes, as well as health education sessions to raise awareness and reduce morbidity stemming from poor diet and other lifestyle risk factors.

THE ESSENTIAL ROLE OF THE NATIONAL HEALTH SERVICE CORPS

The National Health Service Corps (NHSC) plays a critical role in providing care for underserved individuals by placing clinicians in urban and rural communities with serious shortages of health care providers. Without the National Health Service Corps I would not have had the opportunity to touch the lives that I have. Also, I would not have been sensitized to the larger issues that affect this country relative to the uninsured and the underserved populations. I have learned so much about health policy and how taking a systems approach is essential to finding a solution to the problems that plague our communities across this nation.

Currently 2,500 NHSC clinicians, including physicians, dentists, nurse practitioners, physician assistants, nurse midwives, and mental and behavioral professionals, provide health care services to 4.6 million Americans, including 2.2 million health center patients. Caught up in a backlog of legislative issues, the authoriza-

tion for the NHSC unfortunately expired last year. This important program is in peril without Congressional action this year.

While the NHSC program has proven successful in addressing health professional shortages in many areas, severe lack of funding has undermined the program's ability to meet its primary goal. Only $129.4 million was provided for the NHSC for FY 2001. According to HHS, more than 12,000 physicians would be needed to place sufficient providers in all health professions shortage areas (4 times the current number of NHSC providers), and more than 20,000 (8 times the current number of NHSC providers) would be needed to bring all areas of the country to the same staffing ratios for providers that are used by both managed care organizations and health centers. If health centers are to meet the challenge of doubling their capacity to serve the underserved, the National Health Service Corps needs to be doubled to provide the health professionals needed to staff health centers and other health professional shortage areas.

The NHSC also needs to be streamlined to work more effectively with safety net providers, including health centers, which share the goal of improving health care access in underserved areas. The placement of NHSC providers at health centers should be simplified in order to better meet the health care needs of the uninsured and low-income individuals who reside in medically underserved areas. Currently, health centers must apply for designation as a Health Professional Shortage Area (HPSA) in order to be eligible for NHSC placements, although the law already mandates that health centers be located in Medically Underserved Areas (MUA). This duplicative and bureaucratic mandate hinders the ability of health centers to recruit medical professionals in a timely manner.

HEALTH CENTERS NEED THE SUPPORT OF CONGRESS TO FULFILL THEIR MISSION

Health centers request that this Subcommittee and the Congress act to support our work in several specific ways. We have been, and will continue to fulfill our mission of providing high quality health services to the medically underserved at low cost. We will continue to bring needed health care professionals to underserved communities, and to work in partnership locally to meet community needs and to improve health outcomes for the people we serve. Specifically, we need your help in four key ways:

- First and foremost, we need the stability that comes from knowing that you will *reauthorize and strengthen our health centers program,* which provides the core support for our operations.
- Second, we need you to *reauthorize and strengthen the National Health Service Corps program,* a vital partner in the plan to double the number of people we serve.
- Third, we ask for your help in *securing the funding increases needed by health centers and the NHSC* to double the number of people served by health centers over the next 5 years.
- Finally, we ask you to *support the efforts of local safety net providers and others to better organize care for the uninsured and underserved,* such as those funded under the new Community Access Program (CAP).

Reauthorize and Strengthen the Health Centers Program

In 1996, the Congress consolidated four separate targeted primary care programs (Migrant Health, Health Care for the Homeless, Public Housing Health Centers, and Community Health Centers) under a single authority, extending the consolidated program for five years. The new authority also included a limited new provision to fund health center-led networks and a new federal loan guarantee program for managed care. The consolidated health centers authority, at Section 330 of the Public Health Service Act, expires on September 30, 2001, and therefore requires reauthorization this year. Moreover, several key improvements are needed in the current health centers law, including:

- **Restoration of facility construction, modernization, and expansion as allowable uses of funds.** Many health centers operate in facilities that desperately need renovation or modernization. In some cases, rapidly growing patient populations have strained the capacity of existing facilities; other facilities are old, or inadequate for the efficient delivery of primary health care. Almost 65 percent of all health center facilities are more than 10 years old, and 30 percent are more than 30 years old. *A recent survey of health centers found that almost two-thirds of them currently need to upgrade, expand or replace their current facilities.* Moreover, many needy communities are not yet served by health centers—new facilities will have to be built (or existing facilities modernized, expanded or replaced) in order to extend health center services there. Restoring

the government's ability to make grants for capital projects is critical to enabling health centers to maintain, modernize and expand their current facilities—or to replace old facilities or build new ones—to meet the growing demand for their safety net services.

- **Enhancement of current Section 330 loan guarantee authority to cover facility loans.** Health centers' capital needs could also be more successfully met by enhancing the current federal loan guarantee authority in Section 330—which only permits the issuance of loan guarantees to support the development of managed care networks and plans—to include loan guarantees for facility construction, modernization, and expansion, and for acquisition of facilities and equipment.
- **Clarification of authority to support health center-controlled networks.** As noted in my earlier discussion of our Bayou Teche Community Health Network, many health centers currently collaborate with each other, and with other community providers, in a variety of different networks and partnerships designed to improve their cost-effectiveness and to improve access to and the quality of care for their patients, especially uninsured patients. However, support for the ongoing operation of such networks is not authorized under current law, a shortcoming that needs to be addressed, especially in light of the increasing opportunities for health centers to collaborate for the benefit of their patients and communities.

We also support action to: restore a requirement to continue allocating overall health centers program funding across the community, migrant, homeless, and public housing sub-authorities in the same manner as BPHC has done over the past 5 years; ensure a continued focus and targeting of funds on these vulnerable populations; and clarify that certain individuals are eligible for care under the Homeless and Migrant Health programs.

Reauthorize and Strengthen the National Health Service Corps

Health centers strongly support action to reauthorize and increase funding for the NHSC this year. The NHSC also needs to be streamlined to work more effectively with safety net providers, including health centers, which share the goal of improving health care access in underserved areas. Today, some 15 percent of the 6500 clinical providers working at health centers are NHSC Scholarship and Loan Repayment recipients—and the ability of health centers to serve additional people will depend directly on the continued growth of the NHSC. Several key improvements are needed in the program, including:

- **Automatically designate all Federally Qualified Health Centers and Federally Certified Rural Health Clinics that meet the accessibility and affordability requirements (above) as Health Professional Shortage Area (HPSA) facilities.** The NHSC and the health centers programs are intended to address the same goal (to meet the health care needs of underserved populations). As noted earlier, providing automatic HPSA facility status to health centers and rural health clinics, thus making them eligible for placement of NHSC personnel, will reduce bureaucratic barriers and allow coordinated use of federal resource in meeting the health care needs of areas that lack sufficient health care services.
- **Ensure fairness in priority consideration for NHSC placements.** While intended to ensure that all Corps placements were made in areas of highest need, the current criteria used to determine whether a site is included on the high priority placement list has actually had the effect of discriminating against health centers and other similar entities, because it severely restricts the Secretary's flexibility to consider certain factors as indicators of need, including documented access barriers such as linguistic or cultural isolation, transportation barriers, and other factors highly correlated with underservice—such as large uninsured, elderly, disabled, or minority populations. Thus, an area or population distinguished by the above-noted characteristics, but with a relatively low infant mortality rate or what appears to be an adequate supply of health professionals, for example, would be penalized by being deemed a low priority for the placement of a new NHSC assignee.
- **Establish due process rights in cases of HPSA de-designations and priority list development.** Under current law, the Secretary is required to notify interested organizations and individuals in an area of that area's de-designation as a HPSA, but is not required to follow the same procedure in the case of a population group's or facility's de-designation. Furthermore, while current law requires the Secretary to publish annually list of priority placement sites for new NHSC assignments, it does not require notice to entities that are not included on the list, nor does it provide any due process rights to such entities

to provide supplemental information or to file an appeal of their exclusion. Such due process rights are a central part of many other statutes, and should be included in the NHSC law, particularly in view of the consequences of the loss of HPSA designation or priority status to areas that had previously been considered high-priority shortage areas.

- **Require all NHSC Scholarship and Loan Repayment recipients, as well as all NHSC placement sites, to (1) serve all residents regardless of ability to pay (2) bill and collect from third party payers for care furnished to covered individuals and (3) discount normal charges for out-of pocket costs based on ability to pay.** Section 334 currently requires that Corps personnel "...to the maximum extent feasible, provide...services...to all individuals in, or served by, such HPSA regardless of their ability to pay for services..." These provisions need to be applied to all NHSC placements and to be clarified to reinforce the principle that a vital purpose of the NHSC is to reduce access barriers for everyone living in communities lacking health professionals, regardless of their income or ability to pay for services. In addition, language is needed to require the Department of Health and Human Services to monitor this requirement to determine whether Corps personnel and their sites are actually meeting these requirements and to enforce compliance.
- **Eliminate duplication of effort in the placement of NHSC personnel.** After completing their taxpayer-funded medical education, many NHSC Scholars request—and HHS often approves—a waiver of their NHSC service obligation if they agree to establish a "private practice option (PPO)" in a designated HPSA. In most such cases, the Scholar is free to practice in virtually any HPSA (whereas those who fulfill their service obligation through assignment are targeted to high-need HPSAs). Currently, these "private practice option" clinicians are not subject to the requirement that they open their practice to all in the community regardless of ability to pay; and, in some cases, these NHSC-subsidized for-profit practices have been found to resist caring for uninsured—and even Medicaid-covered—patients, instead referring them to nearby health centers and other local safety net providers. Congress should remedy this by restricting PPO placements to HPSAs that are not currently being served by a health center or rural health clinic, except where the PPO clinician is placed at the center or clinic.

We also support action to: allow NHSC scholarship and loan repayment recipients to fulfill their service obligation on a part-time basis, so long as both the recipient and the placement site agree and the total obligation is fulfilled; assist NHSC communities and sites in developing incentives—such as locum tenens, mini-sabbaticals, and continuing professional education—to support the retention of NHSC providers after their service obligation ends; and eliminate the community cost-sharing provision, which is routinely waived for 95 percent of all sites and poses an undue burden both on economically hard-pressed communities and on the NHSC program.

Support increased resources to meet an ever-growing need for care.

Health centers are doing their part to address this problem, but more must be done to serve the growing number of families who do not have access to health care services. More than 16.5 million uninsured individuals currently do not have access to a regular source of health care. *We urge the Committee to actively support the increased funding that is needed to at least double access to care for uninsured and underserved patients in the next five years.* This can be achieved by increasing federal appropriations for health centers—and for the NHSC program as well—by at least 15 percent per year over the next 5 years. This plan would ensure access to quality health care for 20 million individuals by FY 2006, including 9 million uninsured persons.

In Louisiana, our community health center system consists of twenty-six delivery sites across the state. This is far too few for a state that has most of the worse health indicators in the nation and a place where every county or parish is deemed medically underserved and a health professional shortage area. Louisiana is one of the more blatant examples of the need to double the number of people served by health centers. As our state Secretary of Health has indicated its time to invert the pyramid in our state so that primary care becomes the foundation and we build up and out from there. The Teche Action Clinic has already demonstrated the efficacy of this concept by conducting the first public health clinic conversion to that of a community health center. We have also engaged in a planning process with a neighboring parish, St. John the Baptist, to continue this effort in our region of the state. This type of collaboration and partnership goes to the essence of the community health center model.

Assist and support efforts by the core safety net and other providers to better organize care for the uninsured locally.

Last year, Congress provided $125 million in second-year funding for the Community Access Program (CAP), a relatively new effort designed to encourage collaboration among health care providers and other community organizations to improve access to care for the growing number of Americans without health insurance. This new effort is patterned after two similar initiatives undertaken in recent years by major philanthropic foundations (the Kellogg Foundation and the Robert Wood Johnson Foundation). As members of the principal federal program directed at providing access to health care for uninsured and underserved Americans over the past 35 years, we offer the following points for your consideration:

- Health centers welcome any effort that holds the promise of improving access to needed care for the uninsured and for other underserved populations, especially for efforts to help get other local providers to commit to providing needed services for our uninsured patients and others in an organized fashion. *Accordingly, we strongly recommend that this Subcommittee support the continuation of efforts such as those funded under the CAP demonstration;*
- At the same time, we strongly believe that that *any such efforts should complement and do not duplicate the work of other federal programs* that are already targeted at providing desperately-needed services and care to low income, largely uninsured populations—like health centers, the NHSC, Ryan White CARE Act programs, and others as well; and
- Because true safety net providers—those, I repeat, with a legal obligation to provide care to persons who cannot afford to pay—are at the very core of health care delivery for the uninsured in local communities today, and have years of experience and the resulting expertise in organizing the provision of care for this population, then we believe that *these local efforts must clearly include local safety net providers, not just as participants but as core decision-makers and grant recipients.*

CONCLUSION

In summary, health centers are doing their level best to fulfill the expectations of this Subcommittee—and indeed of this Congress and our President. With your continued help and support, we will continue to meet these expectations even as we grow to meet more of the most pressing health care needs in communities all across the country.

As I look over the last 19 years of my career I can honestly say that I can see the fruit of our labor, a priceless gift in one's lifetime. As I work and plan with the staff at home our aim is to have greater than a one-generational impact, not only on our own patient population, but also on the larger community. I think that my experiences can best be reflected in a remark made by one of my patients who I had just seen through a life threatening episode whose visiting daughter asked me how did I come to be in Franklin, Louisiana. I responded that I came via the National Health Service Corps. Her response was while I don't know much about the program you are referring to; all I can say is thank God for the National Health Service Corps. I also thank God for the NHSC and for the health centers program, and the wonderful, often miraculous effects they are having on people and communities all across America.

Thank you for this opportunity to present my views. I and my health center colleagues across the country look forward to working with all the members of the Subcommittee to improve and expand access to vital health care services for many more of America's uninsured and underserved.

Mr. BILIRAKIS. Thank you very much, Doctor.

Ms. Benjamin.

STATEMENT OF KATHRYN BENJAMIN

Ms. BENJAMIN. Chairman Bilirakis, Ranking Member Brown, and members of the subcommittee, my name is Kathryn Benjamin, and I am the Executive Director of SouthEast Lancaster Health Services, an independent community health center, located in the poorest and most diverse section of the city of Lancaster, in Lancaster County, Pennsylvania. Almost 60 employees serve over 11,000 patients each year with high quality, culturally competent

medical and dental services, and are dedicated to eliminating all barriers to care as we continually strive to improve the lives of the underserved in our community.

I want to thank you for the opportunity to come here today and testify in support of the reauthorization of the Section 330 health centers program and the National Health Service Corps, and on the importance of these programs in providing care to the uninsured and underserved in our community. On behalf of the center and our patients, I ask you and the subcommittee to reauthorize these programs this year without delay.

I particularly want to thank my Congressman, the Honorable Joseph Pitts, for your support of our health center and your kindness in asking Chairman Bilirakis if I could come and testify before the subcommittee today. Mr. Pitts, all of us at SouthEast appreciate that you took time from your busy schedule last week and came and visited our center to see our work, and we look forward to working with you on these important programs.

Our center began humbly 30 years ago, with an all-volunteer staff. Despite these modest beginnings, we have worked hard to achieve successes that would not have been possible without the support and guidance of the Section 330 health center program and the National Health Service Corps. These programs helped thousands of health centers like ours to deliver high quality health care to the most vulnerable populations.

We support the changes suggested by the National Association of Community Health Centers to improve the health centers program. The recommendations include an increase in the level of funding of health centers, expansion of construction authority to build facilities in new communities, enhancement of current loan guarantee authority in Section 330 to cover facility loans, and a clarification of funding authority for networks. Without the Section 330 program, SouthEast would not be able to adapt to the rapid changes in the health care industry.

We also support National Association of Community Health Centers suggested changes for improving the National Health Service Corps, including an increase in the level of funding, automatic designation of all federally qualified health centers and federally certified rural health centers that meet the accessibility and affordability requirements as health professional shortage area facilities, and the option of participants in the loan repayment program to fulfill their service obligations on a part-time basis.

What is it about the health center program that I think makes it so successful? The health center law and program expectations, which we at the center refer to as "The Rules." The Rules provide a well thought through recipe to ensure that patients are given expert care when they are in the clinical areas, that all members of the community are able to access this care when they need it, that patients understand their providers and their providers understand them, that chronic illnesses are prevented rather than simply treated, and that racial and ethnic health disparities will soon become a condition of the past.

The health center program expectations are the embodiment of our mission to care for our most vulnerable patients and ensure

that Federal investment in our center is used wisely and cost-effectively.

Eliminating racial disparities and providing culturally and linguistically appropriate care to our patients is of particular importance to us. In the past 20 years, our Southeast neighborhood, like many neighborhoods in your districts, has changed significantly in its cultural make-up. Once predominantly African-American, our community is now mostly Hispanic, with a large African-American and a smaller Asian population. Most Hispanic residents are recent immigrants from Puerto Rico and the Dominican Republic and speak little English.

With Section 330 funding, we have the ability to employ bi-lingual nurses who work intensely with expectant mothers weekly throughout their pregnancies. They provide nutrition counseling, smoking cessation classes, preventive health training, home visits, birthing and parenting classes, all services that ensure that the mother is her healthiest and is prepared to bring a healthy life into this world.

One of our biggest success stories is that last year, for the first time, we eliminated racial and ethnic disparities in our newborns. There were no statistical differences between the newborn weights of African-American, Hispanic, and White babies. This goal, which took us 10 years to achieve, simply would not have been possible without support and funding from the Section 330 program. Our Medical Director, who implemented the program, came to us at the National Health Service Corps and is still with us today.

Also, increased levels of funding have allowed us to employ more diverse and highly trained providers and nurses. Through an increase in our base grant and with the help of the National Health Service Corps, we were able to hire an African-American dentist this year, who has implemented a new outreach program to encourage people of color to access dental services. In one instance, the dentist convinced a 70-year-old African-American woman to come in for a dental visit for the first time in her life, and she happens to be the wife of a very influential, well-educated and prominent person in the community.

I would like to talk specifically about the role of the community in our health center. Like every health center, SouthEast is governed by a board from the community. The composition of our board of directors reflects the diversity of our community and the patients we serve. Over half of our board members are patients of the center, and more than two-thirds represent minorities. Our board members offer substantial expertise in the areas of business, finance, health care, faith-based community organizations, human resources, law, local and regional government. Three pastors sit on the board of SouthEast, representing large minority congregations. They provide valuable insight into the health care needs of the community. As a result of this relationship, the planning has begun to open and operate a clinic in the new community building to be built next year adjacent to the largest African-American church in Lancaster.

Construction funding is greatly needed, as well as ongoing operating funds to provide not only acute health services, but also on-site screening for chronic diseases such as diabetes, heart disease

and HIV, as well as preventive health programs such as smoking cessation, nutrition counseling, health lifestyle and community education programs.

Our role as a safety net provider in our community has been strengthened by recent increases in base funding, and will continue to be fortified if we are allowed to use Section 330 funds to expand our existing facilities and to build new sites.

Our community is facing the closure of two large medical clinics in the next 1½ years. This will leave approximately 15,000 residents without a medical home. Two years ago, two dental clinics closed in the community, and left about 6,000 current patients without dental homes. Our center and one other small center in the county are the only providers right now to low-income patients in the community, and there are 29,000 Medicaid recipients in the county, and we only have enough resources to provide about 8,000 patients with care, so it is a very difficult situation we are facing right now. With expansion funds, last year we were able to hire a new dentist to help serve, and now we need to build new sites.

In order to respond to ever-increasing numbers of uninsured and underinsured in our community, we must have the resources to cast an even larger safety net through the reauthorization of the Health Center and National Health Service Corps programs.

In summary, SouthEast and its community are grateful for the support of this subcommittee and this work. We cannot continue to eliminate disparities in our health care system without the reauthorization and improvement of the Health Centers Program and the National Health Service Corps. We urge the subcommittee to act as soon as possible to reauthorize these important programs. Thank you for the opportunity to appear today. I will be glad to answer any questions.

[The prepared statement of Kathryn Benjamin follows:]

PREPARED STATEMENT OF KATHRYN BENJAMIN, EXECUTIVE DIRECTOR, SOUTHEAST LANCASTER HEALTH SERVICES

Chairman Bilirakis, Ranking Member Brown, and Members of the Subcommittee: My name is Kathryn Benjamin. I am Executive Director of SouthEast Lancaster Health Services (SELHS). SELHS is an independent community health center, located in the poorest and most diverse section of the City of Lancaster, Pennsylvania. Almost 60 employees serve over 11,000 patients each year with high quality, culturally competent medical and dental services, and are dedicated to eliminating all barriers to such care as we strive to continually improve the quality of life for the underserved.

I want to thank you for the opportunity to come here today and testify in support of the reauthorization of the section 330 health centers program and the National Health Service Corps, and on the importance of these programs in providing care to the uninsured and underserved in our community. I particularly want to thank my congressman, the Honorable Joseph Pitts, for your support of our health center and your kindness in asking Chairman Bilirakis if I could come before this Subcommittee today. Mr. Pitts, all of us at SELHS appreciated that you took time from your busy schedule last week to come and visit our center and see our work. We look forward to working with you on these important programs.

THE COMMUNITY THAT SELHS SERVES

SELHS is situated in the middle of a diverse, urban, and medically underserved community. The South East area neighborhood is comprised of over 22,000 people from whom the health center draws most of its patients. In the past twenty years this neighborhood has changed significantly in its cultural make-up. Whereas twenty years ago most of the residents were African American, today it is comprised of 54% Hispanic residents, 32% African American, 5% Asian/Pacific Islanders or Amer-

ican Indian, and 9% white. A majority of the Hispanic residents in Lancaster are recent immigrants from Puerto Rico and the Dominican Republic and, because of this, many of them have little or no English language proficiency. At our health center, 64% of our patients are Hispanic, and 17% are African American.

It was estimated in 1999 that 63% of the residents of the South East Lancaster MUA and HPSA had incomes below 200% of the poverty level, and 35% had incomes below 100% of the poverty level. 95% of our patients live below 200% of the poverty level, and 62% live below 100% of the poverty level. In this community there is only one full-time physician providing services to Medicaid patients for every 6,642 residents, and one full-time dentist providing services to Medicaid patients for every 4,580 residents, indicating the area is a low-income Health Professional Shortage Area or HPSA. The remaining sections of the City of Lancaster that lie outside the HPSA are comprised of less than 7% minority and low-income residents.

HISTORY OF THE CENTER

SELHS had humble beginnings. Thirty years ago two physicians and a nurse volunteered to provide desperately needed care to patients who were not welcome in private practices because they had no money. Small donations from local organizations and philanthropists covered their supply costs. As the noble gesture of these efforts spread, more donations came. Grant funding was applied for and received and in 1980 SELHS became a community health center when it received a grant under section 330 of the Public Health Service Act. Slowly, more services were offered, staff began to receive compensation and more were hired. The organization has not stopped growing during its 30-year lifespan.

THE IMPORTANCE OF THE HEALTH CENTER PROGRAM TO SELHS AND THE COMMUNITY

Our participation in the Community Health Center (CHC) program has been invaluable for SELHS, both from a financial and a programmatic standpoint. The Bureau of Primary Health Care provides not only monetary support for the center to achieve its mission, but it also provides key technical assistance necessary to develop a voluntary organization into one with a continually, financially viable business plan and appropriate managerial organizational structure. Without the section 330 program, SELHS would not be able to adapt to the rapid changes in the health care industry.

The section 330 health center requirements and program expectations ("*the program rules*") are stringent. They cover areas such as board composition and responsibilities, management and financial practices, medical and dental standards of care, best practices and treatment protocols, culturally and linguistically competent staff, and the provision of services that eliminate barriers to accessing care. The rules provide a well thought through recipe to ensure that: patients of SELHS are given expert care when they are in the clinical areas; all members of the community are able to access this care when they need it; that patients understand their providers and that their providers understand them; that chronic illnesses are prevented rather than simply treated; and that racial and ethnic health disparities will soon become a condition of the past. The rules ensure that the federal investment in the program and our health center is used wisely and cost-effectively.

SELHS PROVIDES COMPREHENSIVE PRIMARY AND PREVENTIVE CARE

SELHS' **primary medical services** include two family practice physicians, two internists, and four mid-level practitioners. Services are provided in "pods", each staffed by a provider, an LPN, a medical assistant, and a patient care coordinator during each session. Patients are immediately taken into a private room and all services are provided to the patient in that room. Weights, labs, provider visits, social services, treatments, billing and collections are all provided in the privacy of the patient room. This has dramatically increased patient satisfaction, privacy, and efficiency. The patient no longer needs to move from station-to-station during the visit and wait for staff to be "freed up" to take care of their needs. Our staff go to where the patient is.

Additionally, we have part time contractual agreements with a part-time pediatrician, obstetrician/gynecologist, cardiology group, nephrologist, and chiropractor, all of whom treat referral patients at our main site. The availability of these services has dramatically improved our ability to diagnose and treat a fuller range of diseases, as well as remove several access barriers for our patients who would otherwise not be able to see a specialist in his/her office.

Our prenatal care program is just one example of how SELHS has thrived under the CHC program rules, *as have our patients.* The prenatal program alone has all but eliminated racial and ethnic disparities in the area of low birth-weight babies.

Last year the average Black, Hispanic and White baby of SELHS weighed the same healthy weight. Why does a program like this work? In addition to the bi-weekly and weekly visits with medical providers, SELHS offers an intense, nurse driven perinatal program.

Unlike in private practice medicine, SELHS' perinatal nurses work intensively with each expecting mother on a bi-weekly and weekly basis throughout her pregnancy. These nurses evaluate every aspect of the expecting mother's life and lifestyle. A few of the areas covered are nutrition counseling and the provision of vitamins, stop smoking programs, home visits, preventive health training, birthing classes, parenting classes, and dental care. The goal of our program is to ensure the mother is at her healthiest throughout the pregnancy, is prepared to bring a healthy life into this world, and is prepared to raise a child in a mentally and physically healthy environment. School aged moms are taught how to raise a child while completing their educations. Rarely are babies not wanted by our patients, but if this situation should arise, nondirective counseling on all alternatives, including adoption, is provided.

Programs such as these are expensive and only partially funded by the CHC program. Other local organizations contribute to the costs. Each of these organizations realizes how valuable preventive care is, and that the return on the investment is almost astronomical if we can prevent the use of the neonatal intensive care unit, prevent developmental delay, and ensure that when a child is born it is as healthy as possible. Local donors realize that SELHS cares for the most at-risk population in the community, and that our programs, tailored to the patients' cultural, linguistic, and financial needs, far surpass any other services available in the community. Eliminating barriers is the key to our success.

In addition to our medical services, **primary dental services** are offered on-site by three, full-time general dentists and a part-time pediadontist. Preventive and screening services for children are offered by our hygienist, who works with the local Head Start Program. The dental and prenatal departments work closely together. The prenatal staff refer patients to the dental department as soon as they enter the program. Our dentists not only treat them, but also teach them about taking care of their baby's teeth. Additional dental education is provided in specific courses that are a part of the prenatal/birthing classes.

SELHS has a **pharmacy program** funded partially by the health centers program, but primarily by local organizations and private donors. The most common acute medicines are purchased in bulk, kept in the clinical areas, and dispensed as needed by the providers, at the center's cost. The auxiliary of the local medical society coordinates the pick-up of unused pharmaceutical samples from area physicians, organizes them, and delivers them to the center at least twice a year. And SELHS has a staff member who coordinates our large pharmaceutical company "chronic disease" medicine program. Low income, uninsured and under-insured patients with chronic diseases are eligible to receive free medicines from many of the large pharmaceutical companies. The requirements are not as difficult as they are cumbersome. On a frequent basis the patient's physician must complete forms verifying that the patient is in need of the medicines, and SELHS must verify the patient's income level and insurance status. The medicines are then mailed to SELHS where staff coordinate patient pick-up and dispensing.

The other major part of our pharmacy program is the acute medicine voucher program. About $10,000 per year is donated from local businesses, organizations and private donors, to pay for 100% of individual acute prescriptions for patients who do not have the immediate funds to pay for them.

SELHS offers free prostate screening annually with the help of a local hospital that provides nurses and covers promotional expenses, and a group of volunteer urologists. This year 174 men were screened who might otherwise have not received this valuable check-up. Excellent communication to the community through our board's close relationship with the faith-based organizations has increased the success of this program significantly.

Free HIV screening and counseling is provided on a daily basis in a dedicated office at our main site. The local AIDS Community Alliance provides trained counselors, who work closely with the medical providers, greatly enhancing compliance with treatment protocols and the continuity of care.

COMPREHENSIVENESS OF CARE

SELHS provides more than episodic medical and dental care, and continues to care for patients during periods when they lose their health insurance. There are many services that SELHS provides uniquely in the community. Social services, nutritional counseling, incentives for up-to-date immunizations, and the Reach Out

And Read program are highlights of some of the other services that contribute to our success.

Recognizing that many of our patients face challenges in their daily lives that limit their ability to comply with treatment regimens, SELHS employs clinical support staff who follow the patients after their visits, and provide assistance when barriers come up. Case managers, social workers, eligibility specialists, physician assistants and nurse practitioners intervene when needed. All patients with chronic diseases are "tracked" or followed by staff who find out if they keep specialist appointments, fill their prescriptions, get their laboratory work done at appropriate intervals, and keep appointments at SELHS. When a patient faces trouble in any of these areas our staff offer assistance. Sometimes a simple reminder phone call helps, and sometimes our social worker gets involved, and other times a visit to the patient's home is necessary.

Our experience has shown that once an individual has begun to fully comply with healthy lifestyle changes and/or is following treatment protocols for a period of time, they not only establish life-time patterns of behavior, but they affect their entire family and social network. This is why we are so strongly dedicated to changing the lives of our patients and our commuity, one life at a time.

Environmental issues, such as lead paint, the existence of fire-arms in households, and home safety hazards are all discussed in office visits. School aged children from underserved homes often do not have many of their own books, so we give each child a book of their own at each visit. And we have started the Reach Out and Read program, which provides additional, age appropriate books and readers in our pediatric waiting rooms as well.

CULTURALLY AND LINGUISTICALLY COMPETENT CARE

From our board of directors to our translators, SELHS is committed to providing healthcare and education to our patients and the community in a culturally and linguistically friendly manor. Studies continue to support the theory that people learn best and are most likely to comply with suggested lifestyle changes and treatment programs when they are delivered in their primary language and in a manner that respects and acknowledges their traditional cultural beliefs.

SELHS is the only provider in the community that ensures the availability of translators in the clinical area for those providers who are not bilingual. Employees at SELHS can provide medical translation in almost a dozen languages. Quarterly staff meetings target various cultures and their health beliefs, as part of a program to continually educate, update, and brainstorm on ways to improve our services to all members of the diverse population we serve.

Recruiting bicultural and bilingual providers has been difficult for SELHS. Whereas in the past, the National Health Service Corps (NHSC) has successfully provided loan repayment opportunities to several of our providers, this year we lost a bilingual and bicultural physician because of the shortage of funds in the NHSC program. A year prior we had the good fortune to hire a multi-lingual, bi-cultural, board certified, family practitioner. He would only agree to an extended contract if he would be able to receive loan repayment through the NHSC. Five months after he began employment he received bad news: NHSC was under-funded and, although he qualified for the loan repayment program, there were insufficient funds for that year, and he was welcome to apply the following year. He graciously completed a full year of employment, and then, having no faith in the NHSC, he left our employ.

Hiring bilingual and bicultural, or minority providers has always been a challenge for SELHS. The NHSC offered us a great recruiting tool in the past. The fact that its funding has not been dependable has all but crippled the center's recruitment efforts. Bilingual and bicultural providers are recruited with significant compensation packages all over the country. The fact that the cost of living is significantly lower in Lancaster, PA than the large urban areas is not a sufficient draw. Knowing, without a doubt, that the NHSC loan repayment program is sufficiently funded is paramount to our efforts in recruiting culturally and linguistically competent providers at SELHS. If there is anything you can do to help assist with this problem, we would greatly appreciate it. Please reauthorize the NHSC program and strengthen it as suggested by the National Association of Community Health Centers. I have attached their recommendations to my testimony.

THE COMMUNITY DETERMINES THE CARE IT WILL RECEIVE

Like every health center, SELHS is governed by a board from the community. The composition of our board of directors reflects the diversity of our community and the patients we serve. Over half of our board members are patients of the center and more than two thirds represent minorities. Board members offer substantial exper-

tise in the areas of business, healthcare finance, faith-based community organizations, human resources, law, and local and regional government. Three pastors sit on the board of SELHS, representing large minority congregations. They provide valuable insight into the healthcare needs of the underserved community. As a result of this relationship, the planning has begun to operate a clinic in the new "community building" to be built next year, adjacent to the largest African American church in Lancaster. Construction funding is greatly needed, as will be ongoing operating funds to provide not only acute health services, but also on-site screening for chronic diseases such as diabetes, heart disease and HIV, as well as preventive health programs such as smoking cessation, nutrition counseling, healthy lifestyle and community education programs.

THE HEALTH CENTERS PROGRAM INVESTMENT IN SELHS HELPS ELIMINATE BARRIERS TO CARE

The patients SELHS serves are very poor and have few financial resources: 40% percent are uninsured; 42% have Medicaid coverage; 5% Medicare; and 13% private insurance (including the SCHIP program). We cared for 11,344 patients last year, with 28,360 patient visits. No other organization in our community offers patients a sliding fee based on family size and income. 95% of our patients qualify for some level of reduced fees, most fees being reduced to the minimum fee of $6 for a visit.

The health center grant is the financial underpinning of our ability to care for our patients. Last year, our $864 million grant helped us to write off uncompensated care for the uninsured and underinsured and to provide translation services. Private donations and Medicaid and Medicare payments also support the services we provide. Other grants and private donations contribute to our other enabling programs, such as the outreach programs, perinatal program, Reach Out and Read, our mammogram fund, and our pharmacy fund.

THE ROLE OF THE CENTER IN THE FUTURE OF THE COMMUNITY

SELHS is seen as an organization that touches the lives of almost all, if not all, of the underserved in this community. It therefore serves as a vital link to these individuals from the perspective of many other organizations. The barriers we eliminate come in many shapes and sizes. Financial barriers were the first ones SELHS sought to eliminate. The underserved community knows that they can come to SELHS at any time and never be refused acute treatment for financial reasons. Additional barriers, such as transportation, language, culture, obtaining medications, and scheduling conflicts are all minimized if not eliminated at SELHS.

What is the future of care for the residents of our community? Current market trends have left thousands of underserved members of the community without essential medical and dental services. As more and more people go off of the Welfare rolls, the number of uninsured and underinsured people increases. Few of these people gain employment in organizations that offer medical and dental coverage, and when coverage is available, annual out-of-pocket expenses are high.

SELHS remains the safety net provider for many people who are newly enrolled in managed care plans and assigned to a specific primary care provider. Many are assigned to a provider without their "understanding" because of linguistic issues. These individuals still come here, and we help them navigate the managed care world. We help them make and carry out choices and take care of their needs while they move through the system.

SELHS will remain the safety net provider to patients whose providers stop accepting Medicaid. For decades local providers referred their Medicaid and uninsured patients to SELHS. As private managed care grew, physicians soon realized that Medicaid paid as well as the private HMOs, and began opening their doors to the Medicaid recipients once again. With Medicaid HMOs being mandatory this year, two of the three local hospitals have begun to close down their outpatient clinics. Many private physicians in the community are pulling out of the Medicaid program. Two hospital sponsored dental clinics closed last year, leaving over 5,000 Medicaid patients without a dental home.

SELHS is the designated safety net provider whenever these changes occur. We expanded our dental staff when the hospital clinics closed and have had to prioritize on emergency dentistry first, and preventive dentistry second. We have plans to open a new clinic with some local financial support, but need additional health center grant funds for construction and to ensure continued financial viability.

As more clinics close and physicians refuse to treat Medicaid patients, we must plan to expand to fill the void. And, as we continue to screen and provide outreach education to those with undetected chronic diseases we must be prepared to provide

comprehensive care for them in our system. We are ready to continue to meet the challenges of caring for our community—but we need your help to do so.

WHY THE PROPOSED CHANGES TO THE COMMUNITY HEALTH CENTER PROGRAM ARE IMPORTANT TO SELHS

We support the changes suggested by the National Association of Community Health Centers to improve the health centers program. I have included them as an attachment to my statement. I want to address specifically how some of these will help our center.

1. Reauthorize the program and increase the level of funding

I want to thank you for everything Congress has done to increase funding for health centers over the past few years. We used what we received from increased funding to stabilize and expand services at SELHS, and to begin to fill the void left when other local providers closed their doors to the underserved. SELHS has received service adjustment awards and several increases to our base grant over the past 5 years equaling almost half a million dollars. We received increases in 1999 of $100K, in 2000 of $70K, and $100K for 2001. These increases have made a substantial difference in our community.

SELHS is in a position to triple its capacity to care for the underserved, but will need additional continued financial support to sustain the physical expansions and programs. As more outreach and community education is provided, SELHS must grow to bring these previously untreated members of the community into programs of ongoing medical and dental care. Current projects planned by SELHS that would utilize these funds include the clinic in the African American church, a new medical site without construction costs to serve 5,000 patients, and a new site with construction costs to house both medical and dental, and education services, for 10,000 patients. We cannot do this without the reauthorization and expansion of the program.

2. Expansion of construction authority to build facilities in new communities

SELHS has long recognized the need for a community health center in a neighboring community, in which almost 5% of the center's current patients reside. A new clinic would have to be built to extend services to this community and not only would some construction costs be necessary, but some ongoing operational assistance will be necessary as well. Restoration of the ability for health centers to use a small portion of grant funds for construction down payments will enable us to meet the needs of this neighboring community. Also, if we take on some of the clinics being closed by a local hospital, we will need funds for renovation.

3. Enhancement of current Loan Guarantee Authority in Section 330 to cover facility loans.

As well as a down payment, the facility construction and renovation needs I discussed above and expansions will all require facility financing. Of paramount importance will be the availability of low cost loans with guarantees that would cover a substantial percentage of the cost of this financing—so revision of the loan guarantee program is critical to our work.

4. Clarification of funding authority for networks.

SELHS is a member of CISNP (Community Integrated Services Network of Pennsylvania), a community health center owned network that provides shared expertise in the areas of clinical outcomes management, operations benchmarking, management tools, and managed care contracting. One current CISNP program we hope to participate in is a Management Information Systems program that will lower our costs by jointly contracting for an MIS program and sharing technical expertise. Permitting the grant funds to be used for these purposes would greatly help us reach this goal.

In summary, SELHS and the community it serves is grateful for the support of this Subcommittee for this work. We cannot continue to eliminate disparities in our health care system without the reauthorization and improvement of the health centers program and the NHSC. We urge the Subcommittee to act as soon as possible to reauthorize these important programs. Thank you for the opportunity to appear today. I would be glad to answer any questions.

EXPLANATION OF PROPOSED CHANGES IN THE NATIONAL HEALTH SERVICE CORPS STATUTE

BACKGROUND

The National Health Service Corps (NHSC) plays a critical role in providing care for underserved populations by placing clinicians in urban and rural communities with severe shortages of health care providers. Currently 2500 NHSC clinicians, including physicians, dentists, nurse practitioners, physician assistants, nurse midwives, and behavioral health professionals, provide health care services to 4.6 million Americans, including 2.2 million Health Center patients.

While the NHSC program has proven successful in addressing health professional shortages in many areas, funding limitations have restricted the program's ability to meet its primary goal. According to HHS, more than 12,000 physicians would be needed to place sufficient providers in all health professions shortage areas (4 times the current number of NHSC providers), and more than 20,000 would be needed to bring all areas of the country to the same staffing ratios for providers that are used by both managed care organizations and Health Centers (8 times the current number of NHSC providers). The NHSC also needs to be streamlined to work more effectively with safety net providers, including Health Centers, which share the goal of improving health care access in underserved areas.

PROPOSED CHANGES TO NATIONAL HEALTH SERVICE CORPS AUTHORITY

1. Reauthorize the National Health Service Corps for five-years at not less than $150 million for the first year and for such sums as are necessary for each subsequent fiscal year.

Explanation

Although the NHSC's most recent reauthorization was for a ten-year period, most parties agree that five years is preferable this time. A five-year reauthorization demonstrates continued support for the purpose and role of the NHSC as a federal safety net program; provides for continuity in the administration of the program; and also allows for a more timely opportunity for Congress to review and make modifications in response to changes in the health care environment. The NHSC also warrants a substantial funding increase to address the significant need in designated underserved areas for NHSC Scholarship and Loan Repayment program recipients, and to support other critical activities such as site development, evaluation, faculty and student placement, retention incentives and research.

2. Automatically designate all Federally Qualified Health Centers and Federally Certified Rural Health Clinics that meet the accessibility and affordability requirements (above) as Health Professional Shortage Area (HPSA) facilities.

Explanation

The NHSC and the Health Centers Programs are intended to address the same goal (to meet the health care needs of underserved populations) and are administered by the same federal agency, the Bureau of Primary Health Care. Requiring a health center to obtain a Health Professional Shortage Area (HPSA) designation, even though each health center already serves a "medically underserved area or population" creates a bureaucratic hurdle to placement of NHSC personnel at health centers. Providing automatic HPSA facility status to health centers and rural health clinics, thus making them eligible for placement of NHSC personnel, will reduce bureaucratic barriers and allow coordinated use of federal resource in meeting the health care needs of areas that lack sufficient health care services.

3. Eliminate duplication of effort in the placement of NHSC personnel.

Explanation

After completing their taxpayer-funded medical education, many NHSC Scholars request—and HHS often approves—a waiver of their NHSC service obligation if they agree to establish a "private practice option (PPO)" in a designated HPSA. In most such cases, the Scholar is free to practice in virtually any HPSA (whereas those who fulfill their service obligation through assignment are targeted to high-need HPSAs). Currently, these "private practice option" clinicians are not subject to the requirement that they open their practice to all in the community regardless of ability to pay; and, in some cases, these NHSC-subsidized for-profit practices have been found to resist caring for uninsured—and even Medicaid-covered—patients, instead referring them to nearby health centers and other local safety net providers. Congress should remedy this by restricting PPO placements to HPSAs that are not

currently being served by a health center or rural health clinic, except where the PPO clinician is placed at the center or clinic.

4. Ensure fairness in priority consideration for NHSC placements.

Explanation

While intended to ensure that all Corps placements were made in areas of highest need, the current criteria used to determine whether a site is included on the high priority placement list has actually had the effect of discriminating against health centers and other similar entities, because it severely restricts the Secretary's flexibility to consider certain factors as indicators of need, including documented access barriers such as linguistic or cultural isolation, transportation barriers, and other factors highly correlated with underservice—such as large uninsured, elderly, disabled, or minority populations. Thus, an area or population distinguished by the above-noted characteristics, but with a relatively low infant mortality rate or what appears to be an adequate supply of health professionals, for example, would be penalized by being deemed a low priority for the placement of a new NHSC assignee.

5. Establish due process rights in cases of HPSA de-designations and priority list development.

Explanation

Under current law, the Secretary is required to notify interested organizations and individuals in an area of that area's de-designation as a HPSA, but is not required to follow the same procedure in the case of a population group's or facility's de-designation. Furthermore, while current law requires the Secretary to publish annually list of priority placement sites for new NHSC assignments, it does not require notice to entities that are not included on the list, nor does it provide any due process rights to such entities to provide supplemental information or to file an appeal of their exclusion. Such due process rights are a central part of many other statutes, and should be included in the NHSC law, particularly in view of the consequences of the loss of HPSA designation or priority status to areas that had previously been considered high-priority shortage areas.

6. Allow NHSC scholarship and loan repayment program recipients to fulfill their commitment on a part-time basis. This option would only be available if such service is agreed to by 1) the placement site or sites as well as the scholarship and loan repayment recipients and 2) so long as the total obligation is fulfilled.

Explanation

Flexibility should be provided to enable Scholarship or Loan Repayment program recipients to complete their service obligation on a full-time or part-time basis, with the approval of the placement site. Many small rural communities may not have sufficient volume to support a full-time health care practitioner. In addition, some sites may not need particular types of providers on a full-time basis. Flexibility should be given to the Department to permit part-time service in meeting community needs. In addition, some practitioners may find part-time service more attractive, which in turn could improve both recruitment and retention at these sites.

7. Include a specific allocation for site development and community needs assessment.

Explanation

The NHSC was created to meet the needs of communities that lack access to health care services. In many cases, those shortage communities require physical, oral, and mental/behavioral health care services. Over the years, the NHSC has recognized that each community has unique health needs and has placed a wide variety of health professionals in sites to meet those needs. However, many believe that the NHSC needs to dedicate additional resources to inform and educate communities about the variety of placement opportunities provided by the NHSC, and to assess the real health care needs of communities that are applying for placement of personnel. In order to ensure that communities receive the maximum benefit from the program, the NHSC should allot adequate resources to inform communities of the variety of health care resources available through the NHSC and how those resources can best be used to meet the unique health needs of communities, in collaboration with those communities and other health partners.

8. Assist communities and sites in developing incentives to support the retention of NHSC providers beyond their obligation.

Explanation

Many current and former NHSC recipients have expressed concerns about professional isolation and burnout during their term of obligated service. While most initially declare their intent to remain after completing their obligation, many change their minds by the time their assignments are completed. In many communities, the NHSC recipient may be the only health care professional. As such, they are "on" 24 hours per day, 7 days per week. Providing scheduled breaks for professional development or personal time will increase the likelihood that recipients will remain in these communities beyond the period of their assignment. Examples of incentives might include support for locum tenens, mini-sabbaticals, continuing professional education, and increased practice management technical assistance for current scholarship and loan repayment recipients.

9. Eliminate the community cost-sharing provision (Section 334 of the Public Health Service Act).

Explanation

Section 334 of the Public Health Service Act ("Cost Sharing") requires that an entity to which a member of the NHSC is assigned must reimburse the Federal government for the cost of that NHSC member. In practice, this requirement is waived in almost all cases. In 1998, the cost-sharing requirement was waived in at least 95% of cases and the cost of collecting the remaining 5% of payments exceeded the funds received. This provision should be eliminated because it creates an undue burden on communities (which are economically unstable by definition) in seeking an NHSC clinician, and it poses an unnecessary administrative burden on the NHSC. Clearly, these dollars could be better used in providing access to care. This action is consistent with the spirit of the Paperwork Reduction Act and will facilitate increased usage of NHSC' clinicians by underserved communities.

10. Require all NHSC Scholarship and Loan Repayment recipients, as well as all NHSC placement sites, to (1) serve all residents regardless of ability to pay (2) bill and collect from third party payers for care furnished to covered individuals and (3) discount normal charges for out-of pocket costs based on ability to pay.

Explanation

Section 334 (repealed above) included language requiring that Corps personnel "...to the maximum extent feasible, provide...services...to all individuals in, or served by, such HPSA regardless of their ability to pay for services..." These provisions need to be retained elsewhere in the NHSC statute and to be clarified to reinforce the principle that a vital purpose of the NHSC is to reduce access barriers for everyone living in communities lacking health professionals, regardless of their income or ability to pay for services. In addition, language is needed to require DHHS to monitor this requirement to determine whether Corps personnel and their sites are actually meeting these requirements and to enforce compliance.

RELATED RECOMMENDATIONS:

1. Exclude from Federal income, FICA, and self-employment taxation tuition, fees and related educational expenses to individuals participating in the NHSC Scholarship, Loan Repayment, Community Scholarship and State Loan Repayment program (group with other retention provisions).

Although this falls under the jurisdiction of other Congressional Committees, and must therefore be moved through separate legislation, all parties agree with the NHSC and the NHSC Advisory Council that taxing students adversely affects the financial incentive to participate in the NHSC and provide health care services in underserved communities, many of which are frontier communities.

EXPLANATION OF PROPOSED CHANGES IN THE CURRENT SECTION 330 HEALTH CENTERS AUTHORITY

BACKGROUND

In the 35 years since their creation, America's Community Health Centers have proven their durability as a model health care program and their resilience in adapting to a dramatically changed American healthcare system while maintaining their original mission and purpose.

Health centers were established to provide access to quality preventive and primary health care for the medically underserved—including the millions of Ameri-

cans without health insurance, low income working families, members of minority groups, rural residents, homeless persons, agricultural farmworkers, and those living with HIV or with mental health needs. Since their inception, health centers have served as a prototype for effective public-private partnerships, demonstrating their ability to meet pressing local health needs while being held accountable for meeting national performance standards. The success of the Health Centers program can be directly traced to the core elements found in Section 330 of the Public Health Service Act, its authorizing statute. These elements stipulate that each federally-supported health center must:

- Be located in, and serve, a community that is designated as "medically underserved," thus ensuring the proper targeting of federal resources on areas of greatest need;
- Make its services available to all residents of the community, without regard to ability to pay, and to make those services affordable by discounting charges for otherwise uncovered care to low income families in accordance with family income;
- Provide comprehensive primary health care services, including preventive care (such as regular check-ups and pap smears), care for illness or injury, services which improve the accessibility of care (such as transportation), and the effectiveness of care (such as health/nutrition education);
- Be governed by a board of directors a majority of whose members are active, registered patients of the health center, thus ensuring that the center is responsive to the health care needs of the community it serves.

In 1996, the Congress consolidated four separate targeted primary care programs (Migrant Health, Health Care for the Homeless, Public Housing health centers, and Community Health Centers) under a single authority, extending the consolidated program for five years. The new authority also included a limited new provision to fund health center-led networks and a new federal loan guarantee program. The consolidated Health Centers authority, at Section 330 of the Public Health Service Act, expires on September 30, 2001, and therefore requires reauthorization this year.

PROPOSED CHANGES TO SECTION 330 HEALTH CENTERS AUTHORITY

1. Extension/reauthorization of Section 330 Health Centers authority for at least 5 years, at not less than $1.344 billion for FY 2002 and "such sums" for all future years

Explanation

President Bush has publicly unveiled a multi-year plan to double the number of people served by health centers. More than 60 percent of Members of Congress have endorsed a similar plan. The Congress began that effort by providing $1.169 billion for FY 2001 for Section 330, a $150 million (15 percent) increase from the previous year. This year, a funding increase of at least $175 million will be needed to sustain and continue that effort. Under this plan, more than 10 million Americans will gain access to health center services in thousands of communities across the country.

2. Restoration of facility construction, modernization, and expansion as allowable uses of funds (both Planning/Development and Operational grants)

Explanation

Many health centers operate in facilities that desperately need renovation or modernization. In some cases, rapidly growing patient populations have strained the capacity of existing facilities—these facilities must be expanded. Other facilities are old, or inadequate for the efficient delivery of primary health care—these facilities must be modernized or replaced. *A recent survey of health centers in 12 states found that almost two-thirds of them currently need to upgrade, expand or replace their current facilities.* Moreover, many needy communities are not yet served by health centers—new facilities will have to be built (or existing facilities modernized, expanded or replaced) in order to extend health center services there.

However, most health centers have limited financial capacity to undertake needed facility improvements, expansions or new site development. Because health centers serve a large and growing uninsured patient base, operating margins are slim to non-existent for most health centers. That means that most health centers have only a very limited ability to support loans for their facility needs, and thus must rely on grants and charitable contributions. Yet, because they serve low-income individuals who generally cannot contribute significantly to capital campaigns, health centers have great difficulty raising charitable contributions.

At the same time, construction costs have soared in the strong economy. As a result, the gap between what health centers can afford and the cost of capital projects is growing. Restoring the government's ability to make grants for capital projects is critical to enabling health centers to maintain, modernize and expand their current facilities—or to replace old facilities or build new ones—to meet the growing demand for their safety net services.

3. Enhancement of current Loan Guarantee authority in Section 330 to cover facility loans

Explanation

Health centers' capital needs could also be more successfully met by enhancing the current federal Loan Guarantee authority in Section 330—which only permits the issuance of loan guarantees for managed care-related purposes—to include loan guarantees for facility construction, modernization, and expansion, and for acquisition of facilities and equipment. In 1997 and 1998, Congress earmarked, out of appropriations made for Section 330, a total of $14 million for loan guarantees to 330-funded health centers, both for managed care purposes authorized under Section 330 and for capital purposes as authorized under Title XVI of the PHS Act (although Title XVI continues to exist in the PHS Act, Congress has not directly appropriated funding for Title XVI programs in years). Enhancing the current Loan Guarantee authority to cover facility loans would be consistent with Congressional intent to provide capital loan guarantees for health centers without having to appropriate funds against an otherwise dormant legislative authority, and would also permit other improvements to address shortcomings in current loan guarantee policy, including:

- **Allowing the guarantee to cover more than 80% (and up to 100%) of the outstanding principal amount** would allow lenders to price the loans at significantly lower interest rates by reducing the risk to them. Currently, OMB has determined that the federal loan guarantee for facilities can cover only 80% of the outstanding loan amount provided by a lender. Financial experts have stated clearly that partial guarantees are not sufficient to leverage capital at below-market interest rates, because lenders still perceive significant risk in these loans and fear that, in the event of default, they may not be able to collect even a small amount of the unsecured debt they financed.
- **Refinancing of existing loans** is currently not an eligible use for loan guarantee funds. If the refinancing results in significantly lower interest rates, the savings would benefit both the health center and the government. In addition, some health centers that have experienced financial difficulties are not able to obtain loan renewals from lenders without guarantees, severely limiting their use where they are most needed.
- **Permitting federal loan guarantees to be used with tax-exempt debt financing mechanisms** would allow health centers to access the lowest cost capital available to nonprofit institutions, benefiting both health centers and the government. Because the interest income from tax-exempt bonds is exempt from federal (and sometimes state) taxation, investors require lower returns on their investments than would otherwise be the case for taxable investments. That tax-savings would translate into lower interest rates, allowing health centers to invest more of their operating resources into programs and services for vulnerable populations.

In combination with the restored capital grant authority discussed above, a revised loan guarantee program would be more effective in meeting the pressing capital needs of health centers.

4. Clarification of funding authority for networks at least majority controlled and, as applicable, at least majority owned by health centers funded under Section 330

Explanation

Health centers currently collaborate with each other, and with other community providers, in many different forms of networks and partnerships designed to improve access to and quality of care for their patients, especially uninsured patients. These include *practice management networks,* designed to improve quality through shared expertise (such as centralized pharmaceutical or laboratory services, clinical outcomes management, or joint management/ administrative services), to lower costs through shared services (such as unified financial or Management Information systems, or joint purchasing of services or supplies), or to improve access and availability of health care services provided by the health centers participating in the network. Most of these networks, once developed, need ongoing operational support

to continue and further enhance their benefits. However, current law only authorizes support for the planning and development of managed care networks and plans. Expanding the types of health center-directed networks that can receive planning and development support, and allowing limited operational support for networks that are owned and/or controlled by Section 330-funded health centers, would substantially aid in achieving the health centers' mission and objectives.

5. Restoration of proportional funding allocation requirement for Community, Migrant, Homeless, and Public Housing Health Centers

Explanation

When four separate health center programs (Community, Migrant, Homeless, and Public Housing) were consolidated under a single Section 330 authority in 1996, the law included a requirement for allocating funds appropriated under Section 330 for each of the consolidated programs in accordance with the proportion of total funding they each had received in FY 1996. Despite the fact that this statutory funding allocation requirement expired in 1998, BPHC has continued to adhere to the methodology in distributing overall Health Centers funding among the Community, Migrant, Homeless, and Public Housing health centers. Vulnerable populations have benefited from BPHC's actions, and would be best served by restoring the original funding allocation methodology to the overall statute, thus ensuring the continued distribution of Section 330 funds to key underserved populations such as farmworkers, homeless persons, and public housing residents.

6. Clarification of eligible populations under Migrant and Homeless Health Center sub-authorities

Explanation

During consolidation of the health center authorities in 1996, coverage for formerly homeless individuals during the first 12 months following their transition to permanent housing was inadvertently dropped. Also, current authority fails to specify homeless youth as eligible for services, even though they remain a key homeless population. In addition, current law fails to recognize as eligible for services many farmworkers who, due to changes in agricultural employment, migrate for employment purposes but remain in farm work all year. Clarifying the eligibility of farmworkers employed on a year-round basis, as well as homeless youth and formerly homeless persons following their transition to permanent housing would ensure that the program remains appropriately targeted to the most vulnerable populations.

7. Clarification on provision of required services

Explanation

Under Section 330, all federally-supported health centers are required to provide or arrange for certain key health and related services, including medical, diagnostic lab and radiology, pharmaceutical, preventive dental, and patient case management services. Centers may also furnish additional services if needed by their patient populations, if resources are available.

Despite the statutory requirement, many health centers (especially newer centers and those serving rural communities) have not been adequately funded to support the provision of all required services. While this disparity has been reduced somewhat in recent years and may eventually be eliminated, and while the statutory requirement to provide comprehensive services remains a vital part of the health center model, clarification is needed to ensure that federally-supported health centers are expected "to the maximum extent practicable" to provide all required services, subject to available resources (both federal grant and other resources).

Mr. BILIRAKIS. Thank you very much, Ms. Benjamin.

Mr. Brewton.

STATEMENT OF DAVID BREWTON

Mr. BREWTON. Chairman Bilirakis, Ranking Member Brown, and members of the committee, my name is David Brewton. I am Director of Development for the East Liberty Family Health Care Center, a faith-based community health center that has successfully provided quality, whole-person health care for residents of the city of Pittsburgh for nearly 20 years, without regard to ability to pay. While I have been employed by the Center for 5 years, my family

and I have been patients there since literally the first day the Center opened in 1982, so I am well-acquainted with the quality, compassionate, and accessible care the Center provides each day to all who come.

I want to thank you for the unwavering support this subcommittee has given our health center and our colleagues around the country in our work to care for the uninsured and underserved. I come in support of the National Association of Community Health Centers' position in regard to the extension, reauthorization and expansion of the Section 330 community health centers program and the National Health Service Corps.

I want to emphasize today that we are a demonstration of how a faith-based health center can produce effective health outcomes for the underserved by combining the power of faith-based care with the institutional strength that comes from full participation in the Section 330 health care centers program.

Our Center was incorporated as a 501(c)(3) non-profit corporation in 1982. Our founding physician, Dr. David Hall, had a deep sense of calling to provide health care holistically for the poor in his hometown of Pittsburgh, and to do so as an expression of his conviction that true healing incorporates the physical, mental, emotional and spiritual dimensions of the human person. A local pastor shared his vision and so in 1982 the Center opened up a small office in the basement of Eastminster Presbyterian Church in the heart of East Liberty.

Today, the Center operates two much larger offices in the East End, and last year provided more than 27,000 patient encounters in home, office and hospital, without regard to ability to pay for more than 5,000 individuals. The Center now employs a staff of 760 with a budget of more than $3 million, and provides more than 10 distinct forms of outreach to the low-income community it serves to meet needs beyond the walls of its two welcoming, culturally sensitive offices.

Faith-based and federally funded, we at the Center believe these two forces are a powerful combination to effectively serve everyone in our community: insured, uninsured, Medical Assistance, Medicare, homeless, and even those who are privately insured but want quality care with a difference.

Here is the difference that our faith-based perspective makes: Our faith reminds us of the dignity in every human being, created in God's image, even perhaps especially those who do not share our particular religious values. That is why we are in an underserved community and why we never turn anyone away.

Our faith provides a motivation that makes our practitioners stay with us longer than in most such demanding settings. In our 19-plus years, we have had four National Health Service Corps participants, all of whom are still serving at the Center today out of a sense of God's calling. So they develop relationships with their patients, most of whom have never had a primary care physician before, and were used to relying solely on strangers in emergency rooms for care. This relationship with a family doctor is something that most of us take for granted.

Our faith perspective means that we offer prayer with every visit, and please, we do not force or require prayer, we simply offer

it at the conclusion of each visit, gently and respectfully. Some patients decline, and we fully respect that decision. There is no pressure. Sometimes a patient from a different religious background, including Jewish and Muslim, will also ask for prayer, and we are careful to do so in a way that respects our similarities and differences.

Finally, our faith-based perspective means that we have not just a compassion for people, but a passion for quality care. It should not surprise you then that we have been innovators and results-producers since our inception. Our Homebound Elderly Outreach Program has been named a "Best Practice in Faith-based Health Care" underwritten by the Bureau of Primary Health Care.

A few years back, we documented 92 percent compliance with State immunization requirements for all patients through age 2, when the region's largest Medicaid HMO had a rate of just 62 percent.

We participate in research studies at Pittsburg's fine universities to help improve our patients' care. And we are on the cutting edge in some administrative areas, implementing a computerized medical records system, the bane of our practitioner's existence currently, which will, we trust, enable us to measure health outcomes. And we are a founding member of the nationally recognized integrated health care delivery system called the "Coordinated Care Network", or CCN, that is transforming the way managed care works in Pittsburgh for those on Medical Assistance and the uninsured. I would mention that this is a CAP-funded program.

The CCN achieves its goal by recapturing savings generated by reduced hospital admissions because of primary care, and it enables us to put that money back into better wraparound preventative care for these high-cost users of the medical system in Pittsburgh. And to demonstrate these achievements I have included our annual and Health Care and Business Plans from our 330 proposal.

Please be clear: our faith never, never leads us to exclude anyone, in fact, just the opposite, it compels us to be open to all. If we did exclude anyone, you would have a right to judge us harshly for we would not be supporting the goals that we all share, 100 percent access to care and zero disparities, which brings me to my second and final point.

Here is the difference that Federal support makes. For our first 17 years, we relied solely on private charitable support to make up the difference between the cost of the care we provide and what our patients can pay. Most of that comes from church-going people—and, by the way, those folks continue today to provide well over $1 million per year to pay for the parts of care that no one else will. But in 1999, we were one of the top ten applicants in the country in a competitive cycle, and became a fullfledged CHC, and without this reliable, renewable support we could never have grown to meet the real needs in our community.

Private support, while significant, is just not enough. Without CHC funding we couldn't have opened our second office in a more underserved community than our first. We couldn't have started our dental program, our addiction outreach program, or our important programs in obstetrics, gynecology and parent education. We

couldn't have seen our annual visit more than double from just 12,000 in 1996 to 27,000 last year. And about now we would have been overrun and had to close our doors by the more than 1,000 new patients who were added to our rolls just this year because of Welfare Reform and Pennsylvania's Managed Care Initiative for those on Medical Assistance.

Beyond that, we would like to say that the guidelines and regulations of the Community Health Center Program, while sometimes seeming to be onerous, are actually strong encouragements for us to be more accountable and more outcome-oriented in all we do. It is often tempting to grumble about "the Rules", but our view is this: If we are going to be faithful, we should see government standards as minimum standards and do our best to achieve or even exceed them.

So, I urge you, therefore, to extend, reauthorize, and expand the vital 330 program and the National Health Service Corps to strengthen these programs in accordance with the proposed improvements of the National Association, and I have included these in my written statement.

Thank you so much for the opportunity and honor to present my views here today.

[The prepared statement of David Brewton follows:]

PREPARED STATEMENT OF DAVID BREWTON, DIRECTOR OF DEVELOPMENT, EAST LIBERTY FAMILY HEALTH CARE CENTER

Chairman Bilirakis, Ranking Member Brown, and Members of the Subcommittee: My name is David Brewton, and I am Director of Development for the East Liberty Family Health Care Center, a faith-based community health center that has successfully provided quality, whole-person health care for residents of the City of Pittsburgh for nearly twenty years, without regard to ability to pay. While I have been employed by the Center for five years, I and my family have been patients there since literally the first day the Center opened in 1982, so I am well acquainted with the quality, compassionate, and accessible care the Center provides every day to all who come.

I want to thank you all for the unwavering support this Subcommittee has given our health center and our colleagues around the country in our work to care for the uninsured and underserved. I come in support of the National Association of Community Health Center's position in regard to the extension, reauthorization, and expansion of the Section 330 community health centers program and the National Health Service Corps (NHSC). The unique perspective that I wish to emphasize in my comments is that we are a demonstration of how a faith-based health center can produce effective health outcomes for the underserved by combining the power of faith-based (or what we call "whole-person") care with the institutional strength that comes from full participation in the section 330 health centers program.

Our Center was incorporated as a 501(c)(3) non-profit corporation in 1982. Our founding physician, Dr. David Hall, had a deep sense of calling to provide health care wholistically for the poor in his hometown of Pittsburgh, and to do so as an expression of his conviction that true healing incorporates the physical, mental, emotional, and spiritual dimensions of the human person. The Rev. Douglas A. Dunderdale, Senior Pastor of Eastminster Presbyterian Church, had been praying for a health ministry out of his church, located in the heart of a severely medically-underserved community in Pittsburgh's East End. When the two came together, they knew that it was a confirmation of their visions, and in 1982, the Center opened up a small office in the basement of Eastminster Presbyterian Church. It is important to note that while a Presbyterian Church provided us our start, the Center is non-denominational, and an expression of ministry supported by persons of many different faiths who share a common sense of mission.

Today, the East Liberty Family Health Care Center operates two offices in the East End, and last year provided more than 27,000 patient encounters without regard to ability to pay for more than 5,000 individuals. The Center employs a staff of 60 with a budget in excess of $3 million, and provides more than ten distinct

forms of outreach to the low-income community it serves to meet needs beyond the walls of its two welcoming, culturally-sensitive offices.

Faith-based and federally funded, we at the Center believe that these two forces are a powerful combination to effectively serve everyone in our community: the insured and the uninsured, those on Medical Assistance and Medicare, the homeless, and yes, even those who are privately insured but want quality care with a difference.1Here's the difference our faith-based perspective makes:

- It provides a value system with deep historical roots that helps us to care not only for the physical, but all dimensions of human existence. It reminds us of the dignity of every human being, who is created in God's image—even, and perhaps, especially, those who do not share our particular religious values. That is why we are in an underserved community, and why we never turn anyone away.
- It provides a motivation that makes our practitioners by and large stay with us for longer than in most such demanding settings. In our 19+ years, we have had four NHSC participants, all of whom are still serving at the Center today out of a sense of God's calling. (How's that for retention!) This enables them to develop lasting relationships with their patients, most of whom NEVER had a primary care physician before, and were used to relying solely on strangers at emergency rooms for care. Because of this spiritually motivated commitment, our "poor" patients develop the kind of lasting relationships with their own family doctors at the Center that most of us take for granted.
- It means we spend time—lots of it—with each patient to get to know the whole person, even when insurance and federal subsidy won't pay for that time. This is why one patient spoke for many when she said recently: "When I'm with Dr. Hall, I feel like I'm his only patient."
- It means we offer prayer with every visit—and please note—we do not force or require prayer, we simply offer it at the conclusion of each visit, gently, and respectfully. Some patients decline, and we fully respect their decision. There is no pressure. Others specifically request it and will testify that it is the primary reason they come to us for care (never mind that we employ 11 outstanding board certified physicians with years of experience and from some of the best medical schools in the country). Sometimes, our patients from different religious backgrounds, including Jewish and Muslim, will also ask for prayer, and we are careful to do so in a way that respects our similarities and differences.

Finally, it means that we have not just a compassion for people, but a passion for quality care. Our faith motivates us to provide the best care we can and to strive to measure the results. So, it should not surprise you that we have been innovators and results-producers since our inception: All of our physicians are Board certified. Our founder has received numerous awards in the community for community outreach. Our Homebound Elderly Outreach Program has been named a "Best Practice in Faith-based Health Care" in a national competition, underwritten by the Bureau of Primary Health Care (BPHC). A few years back, we documented 92% compliance with State immunization requirements for all our patients through age 2, when the region's largest Medicaid HMO had a rate of 62%. We participate in research studies at Pittsburgh's fine universities to help improve our patients' care. And, we are on the cutting edge in some administrative areas, implementing a computerized medical records system to measure outcomes among our populations, and being the founding member agency of a nationally-recognized integrated healthcare delivery system (the "Coordinated Care Network," or CCN) that is transforming the way managed care works for those on Medical Assistance and the uninsured. Simultaneously, the CCN is re-capturing the savings generated to provide even better wraparound, preventive care for these high cost users of the medical system in Pittsburgh. (To demonstrate our achievements, I have included as Attachments A and B of my statement our 2000 Annual Report and our Health Care and Business Plans.)

Please be clear: our faith NEVER leads us to exclude anyone, in fact, just the opposite: It compels us to be open to all. Period. If we did exclude folks, you would have a right to judge us harshly, for we would not be supporting the goals of the community health center program which we all share: 100% access to care and zero health disparities.

Which brings me to my second and final point. Here's the difference federal support makes:

For our first 17 years, we relied solely on private charitable support to make up the difference between the cost of the care we provide and what our patients can pay. Most of it comes from church-going people, by the way, who continue today to provide well over $1 million per year to pay for those parts of the care we provide that no one else can or will.

But in 1999, we were one of the top ten applicants for health center funding in a very competitive cycle, and so became a full-fledged CHC. Without this reliable, accountable, and renewable support, we never could have grown to meet the real needs in our community. Private support—while significant—is simply not enough!

Without CHC funding, we couldn't have opened our second office in the even more underserved community of Lincoln-Lemington, two miles from our home office. We couldn't have started a dental program, our addiction outreach program, or our important programs in ob/gynecology and parent education. We couldn't have seen our annual visits more than double from 12,000 in 1996 to more than 27,000 in the year 2000. And about now, we would have been overrun and had to close our doors to the more than 1,000 new patients who were added to our rolls just this year, because of welfare reform and PA's managed care initiative for those on Medical Assistance.

Beyond that, we would like to say that the guidelines and regulations of the community health center program, while sometimes seeming(!) to be onerous, are actually strong encouragements for us to be more accountable and more outcome-oriented in all we do. It is often tempting to grumble about regulations and standards, but our view is this: if we are going to be faithful to our God, we should see government standards as MINIMUM standards, and do our best to achieve or even exceed them.

Through our participation in the CHC program, we have had the opportunity to pursue JCAHO accreditation (we hope to complete this process in the next year or two), to participate in collaboratives with other groups around specific issues to improve our handling of high-incidence diseases such as diabetes and hypertension, and just the accountability that comes through knowing that we are responsible for meeting the goals we set for ourselves in our annual federal review process.

Are there areas of tension in this alliance of faith and government funding? Undoubtedly. But as long as we focus on our common objective (100% access, 0 disparities); and recognize that both church and state have a role in the promotion of the public good, and are clear about the distinctions of those roles, we believe that we are a forthright demonstration of how the two can work together in integrity and accountability.

I urge you to extend, reauthorize, and expand the vital Section 330 Health Centers and the National Health Service Corps programs, and to strengthen these programs in accordance with the proposed improvements of the National Association of Community Health Centers. I have included these proposals as Attachment C of my statement.

Thank you again for the opportunity to present my views here today. I would be pleased to answer any questions you may have.

Attachment A

Caring for the Whole person

Annual Report 2000

and Final Report on
"The Campaign for Whole-person Health Care for the Twenty-first Century."

"For Thou didst form my inward parts, Thou didst knot me together in my mother's womb. I praise Thee for I am fearfully and wonderfully made. Wonderful are they works!"
Psalm 139: 13-14

Reflect with us for a moment on the amazing wonder of the human body:

- A baby is born, and mother and father marvel at the unspeakable miracle...
- Daily that baby develops intangible qualities which transform a physical body into a person: a personality, a will, a heart, a spirit, and along with them, a smile or whole-face-frown that instantly translate the intangibles into the tangible.
- By high school, the developing person studies biology and learns in ever-greater detail the amazing complexity of the human body, and how all the internal systems work together to effortlessly perform the daily functions that we take for granted.

- Two people make a lifetime commitment of marriage and celebrate their union bodily in an act of spiritual and physical one-ness.
- Over time, the body ages, creaks and groans, expands and sags, until at some point, life is no longer contained in that failing body. We see a shell, and we look and long for a restored, transformed, renewed, imperishable body.

When we in the *Center* speak of "whole-person care," we ***begin*** with this understanding: that our visible bodies and invisible spirits are bound together in God's creation and are fearfully and wonderfully made. We join good science and deep faith to attempt to bring healing and hope to the wondrous persons who come to our two offices for care. And when we start with the fact of our wondrous creation by our wondrous God, it makes all the difference. It affects everything we do.

- It's why we are open to all: for all of us are made by the same God in His very image.
- It's why we strive to link counseling, social services, and spiritual support with our care: for health is about much more than the physical.
- It's why we take the time – lots of time – to listen to our patients' stories: for care is about much more than making the right diagnosis, it's about love and trust.
- And it's why we offer prayer with every visit: because the One who made us is the only one who can restore us to whole-person health: physical, emotional, and spiritual health.

Now the reality of our human existence is this: None of us is fully whole; none of us is fully broken. God's image is in each one. But the broken-ness of sin and sickness is also in each one.

So we celebrate the great steps we've made as a ministry toward healing and wholeness, but we remember that much remains to be done. Health and wholeness will never be complete. But oh, the joy of being a part of the process of restoration! God has allowed us to achieve much; much remains to be done. Won't you join us in our mission?

Mission Statement: The East Liberty Family Health Care Center is dedicated to witnessing to God's love, known in Jesus Christ by providing quality, whole-person health care to all, especially the poor.

Accomplishments of the "Campaign for Whole-person Health Care for the Twenty-first Century" (1997-2001)

- Opening of the *Center*'s first satellite office: the Lincoln-Lemington Family Health Care Center, March, 1998.
- Creation of the Coordinated Care Network (CCN) to join with twelve other agencies to bring whole-person care to virtually all of Allegheny County's uninsured and Medical Assistance recipients.
- Renovation of the East Liberty Office (in memory of Mr. and Mrs. William H. Ochiltree) for greater patient volume and efficiency.
- Implementation of a single computerized record system that includes scheduling, billing, and medical records.

- Purchase of the Dorothy Day Apartments, construction of the *Center*'s first Dental Office, and renaming of the entire Lincoln-Lemington facility in memory of The Rev. Dr. Bruce W. Thielemann.
- Addition of seven new services to our "whole-person care" model: Obstetrics/gynecology, addiction outreach and case management, mental health counseling, parent education, podiatry, dental care, and transitional housing.
- Doubling of our patient volume from 12,000 visits in 1996 to more than 27,000 visits in 2000!

Accomplishments of the Year 2000

- Provided a record 27,000+ patient services without regard to ability to pay: for the insured, uninsured, the homeless, and those on Medical Assistance and Medicare.
- Delivered a record 63 babies, with only four below normal birthweight
- Provided for the first time ever 399 dental visits
- Provided for the first time ever 86 podiatry visits
- Provided 2,500+ home visits to the homebound elderly, providing medical and daily living assistance, preventing more than 30 unnecessary hospitalizations. As a result, this program was named a "Best Practice in Faith-Based Health-Care in a National Competition.
- Provided in-home pediatric services for more than 50 families
- Supported 94 persons in recovery from addiction to drugs and/or alcohol, helping 64% of them maintain continuous sobriety throughout the year
- Conducted a patient satisfaction survey showing a >90% satisfaction rate among our patients
- Began strategic planning with Board, staff, and community experts to begin discerning God's direction for the next five years.

Whole-Person Care in the Words of our Patients

Primary Care
Long-time patient, Verneeta Griggs: I trust in the Lord, and I trust Dr. [David] Hall. Whenever I have any problem in my life, I can ask him anything. The quietness with which he speaks reassures me. We just talk about it and he prays for my peace, and that helps me. And I pray for him and the *Center*, too, that they would stay in Him, that their strength and peace would be rooted in Him."

Pediatric Home Outreach
Ms. Daniell Arms, mother of pre-mature twins Dai-mon and Dai-jah: "When I moved way out of town to escape the bad influences of my old crowd, Susan Triggs (RN) didn't leave me. She came to my home to give my twins the medicine they needed because of their pre-mature birth. When I couldn't get ACCESS to provide transportation, Susan could! When one of my twins was sick in the evening, she came all the way out, took us to the hospital, and brought us back home around midnight. So this past New Year's Eve, when I decided to give my life to Jesus Christ, Susan was the first person I called. Then the *Center* got me a Bible to read. Susan is always there for me."

Homebound Elderly Outreach
Patient Paul Sandfield: "Last year, I had two heart surgeries, and other operations. My left leg was removed. The *Center* had cared for my father in his home until he died, so when I lost my leg I asked them to care for me. Debbie [Keck] comes every week, checks my blood and orders my medicine. I take many medicines, three times a day. George [Rivers] comes and picks up my medicine at the drug store once a week. He also gets my groceries for me and brings them in, because I never get out of my place. If they didn't come, I absolutely would NOT go to a nursing home, so I suppose I'd just stay here until I was deceased. But I sure couldn't manage without Deb and George."

Obstetrics
New mother, Sharine Edwards: "[Dr.] Irene [Frederick] was wonderful the whole time. I had a lot of complaints during my pregnancy, and she answered every one, never making me feel judged. She was so attentive. She never left my side during the whole delivery. She did everything possible, including massage to avoid a C-Section, but when it became necessary, she supported me through that. We prayed before, during, and after. When Charonn was born, Irene gathered all my family and friends into the room and the seven of us all prayed. She still checks up on me: When I was going through some post-partum depression, she even called me when she was on vacation."

Homeless Outreach
Homeless Patient, Harold Hughes: "Doctor Pete [Peter Murray, Physician's Assistant] helped me when I buried my mom and was homeless for awhile. I broke up with my wife and he got me medication for my depression. I am a diabetic, and he got me the right medicine for that. He always has love and kindness. We always pray. He goes to my church [Samaritan Worship at East Liberty Presbyterian, where Pete is a member]. When my mom died and my wife was gone, Peter was an inspiration of love and care to not give up on God or this world."

Community Recovery Services
Recovering Addict, Sheila F.: "Where would I be without Bobby [Booker, Addiction Outreach Worker]? I relapsed last year in the worst way. My face got cut. I checked into detox and had to be released in 5 days, but I wasn't ready. There were no beds available in rehab. A girlfriend took me to a meeting where I talked about my fear of "picking up" again. After the meeting, this man (Bobby) spoke to me, and he got me into rehab the next day. When I had to go to court, Bobby went with me. I had to spend a week in jail, and when I got out, Bobby was the first person I called. He got me into the Zoar Program, which I completed last year. I went to more than 90 meetings in 90 days. Now, I have a job, I'm going to Community College for Drug and Alcohol Counseling, Before, I "belonged" to a bar; now I'm the Vice President of the Sorority at my church. Now, I chase recovery like I used to chase the drugs. I just love Bobby. He's my mentor, he checks up on me and sometimes, even calls my mom to check on me. There's no doubt in my mind that this is a lifelong friendship."

Parent Education (with Arsenal Family & Children's Services)
Gloria Morris, raising her grandson Markeith: "[Parent educator] Janet [Edwards Anti] is patient with him, and shows me how to be more patient. I've gotten control of myself, now. I know how to deal with him. I don't get as upset as much. I speak like Janet does instead of hollering at him. Before I was timid and would boil over. Now, I know to be specific and stren to help him know what I expect and that I mean it. Now, my grandchild says to me, "I'm not going to be like that anymore!"

Counseling Services (with Pittsburgh Pastoral Institute)
"I knew I was emotionally falling apart, but I couldn't get it together to ask for help. I came into the Center for a physical problem, and Pete Murray told me that their counselors would be there the next day to screen for depression. He helped me sign up--I knew I could do that much. That we the first step that gave me hope to begin making some positive changes in my life. I'm feeling much better already."

Attachment B

East Liberty Family Health Care Center
BPHC Section 330 Community Health Center "New Start" Program
Health Care Plan

I. Problem/Need: The need to inc. access by the underserved/vulnerable to comprehensive primary and preventive health care. The need to replace reliance on Emergency Room and Hospital-based care for primary care needs with preventive, primary care.

Goals, Objectives, BPHC Funding Source	**Key Action Steps**	**Data Source/ Eval. Method**	**Progress/ Outcomes**	**Comments**
A. Increase # of unduplicated MA, MC, Uninsured, and Homeless Patients seen at the *Center* by 150% in two years(CHC)	A. Open new office in Lincoln-Lemington; hire staff to increase capacity. Carry out "Outreach Plan" (See Business Plan) to attract new patients.	A. Measure implementation of Outreach Plan by goals set in Plan.	***Total active patients seen at both sites has increased from 5,397 @ 3/1/00 to 7,001 on 10/31/00.***	Based on unduplicated patients seen in first 8 months of current fiscal year.
B Add 2,400 new MA patients. (CHC)	B. Work with CCN and Gateway to attract new "Health Choices" patients.	B. Prac. Mgmnt. System will track.	***Net gain of 495 MA patients in 1st 8 months of contract period.***	***From 1,781 on 3/1/00 to 2,276 on 10/31/00.***
C. Add 795 new MC patients. (CHC)	C. Publicize Homebound Elderly Program at local churches and agencies.	C. Same as A1.	***Net loss of 31 MC patients in 1st 8 mos. of contract.***	***From 486 to 455 pts. (same dates)***
D. Add 1,590 new Uninsured Patients. (CHC)	D1. Continue outreach to homeless, addicted." D2. Contact min. 12 homeless/ wk. by regular visits to shelter. D3. Explore proposal to have on-site Clinic at EECM Drop-in Ctr.	D. Same as A1	***Net gain of 525 uninsured patients in 1st 8 months of contract. On-site clinic established.***	***From 1,295 unins. patients on 3/1/00 to 1,820 on 10/31/00.***
E. Decrease ER utilization by new patients by 50%. (CHC)	E1. Provide whole-person, preventive care to patients. E2. Prevent min. of 20 ER visits by Homecare Intervention.	E. Hospitals provide ER util. Data semi-ann.	***E1. CCN has provided baseline data: 2nd Qtr. 2000: 144 ER visits by 103 MA pts., Will track in future qtrs. E2. Homecare documented 20 cases where intervention prevented ER adm. In 1999. 2000 data not yet available.***	***CCN also tracking ER visits/1,000 member-months. In 1st qtr. 2000, our East Lib. Office was 700.32 and Linc-Lem. was 576.99, compared to the MA MCO local average of 683.06.***

Problem/Need: Health Disparities: Infant Mortality remains above 17/1,000 in the East End, and is approximately double that among African-Americans.

Goals, Objectives, BPHC Funding Source	Key Action Steps	Data Source/ Evaluation Method	Progress/ Outcomes	Comments
A. Reduce Teen Pregnancies among patient population by 10%. (CHC)	A1. Incorporate abstinence & birth control education in all visits above age 12. A2. Refer a min. of 50 teens to youth programming through Families & Youth 2000.	A1. Automated clinical records will track. A2. Practs will note referrals to FY 2000 on patient chart. Semi-annual follow-up with partic. churches.	*A1. Education component is implemented for all patients.* *A2. No data available.*	*A2. The FY2000 collaborative has seen some programs disband, and insufficient funding for network referral tracking.*
B. Ensure approp. Pre-natal care in first-trimester to min. of 90% of high-risk/teen pregnancies through new ob program. (CHC)	B1. Training of staff in pre-natal care and early diagnosis. B2. On-site referrals to new ob/gyne on staff.	B2. Ob staff will monitor pre-natal care and report to central administration.	*B1. Two in-services completed, plus 1-on-1 consults with MDs by Ob/Gyne implemented.*	*Ob volume has grown from 24 pregnancies in 98-99 to 65 in 99-00.*
C. Support women in recovery to reduce likelihood of addicted NICU babies. (CHC)	C. Provide intensive case management to 100 recovering addicts through CRS program.	C. CRS provides monthly statistical supports to County.	*No pregnancies reported in current CRS caseload.*	CRS oper'l for 30 mo, helping >170 addicts stay clean.
D. Ensure prompt post-natal care and enrollment in well-child program. (CHC)	D1. Conduct Home Visit to all newborns in practice within 1 week of birth. D2. Improve well-child compliance by home visits, transportation when needed, and telephone visit reminders.	D. Ob staff, assisted by automated clinical records will monitor compliance. Ped. Outreach nurse provides monthly reports.	*D1. Not yet implemented.* *D2. Our Pediatric Nurse has made an aver-age of 30 home visits per month in the contract period.*	New study shows home visits in first week reduces child abuse and increases well-child compliance.
E. Improve parenting skills for high-risk families. (CHC)	E1. Provide 6-8 weeks of parent education for min. of 30 patient families.	E1. Monitored and reported by Pediatric Outreach Nurse/Parent Educator.	*E1. One class has been offered during the contract period. 6 successful completers.*	*2nd class scheduled for next month.*

III. Problem/Need: Children need prompt immunizations and comprehensive, preventive well-child care in the first two years of life. Research shows that prompt immunizations correlate to better overall health and child development.

Goals, Objectives, BPHC Fund Source	**Key Action Steps**	**Data Source/ Evaluation Method**	**Progress/ Outcomes**	**Comments**
A. Achieve 90% compliance by all target population patients for full immunizations by age 2. (CHC)	A1. Continue computerized immunization tracking program. A2. Enroll 200 new patients in program, A3. Provide Pediatric Home Outreach or transportation assistance for non-compliant patients.	A1. The *Center* maintains a dedicated computer to track its pediatrics immunization. This data is compared with rates from region's largest MA HMO.	A1. ***Computer tracking system was obsolete. New system purchased in 1998. Immun. Tracking not yet implemented. Will be operational by 2001.*** ***A2. New pediatric patients receiving well child care & immunizations:*** ***A3. More than 30 home visits/mo. conducted.***	Our 90% rate compares to 56% among all MA recipients enrolled in region's largest MA HMO.
B. Provide comprehensive well-child care for min. of 500 new patients. (CHC)	B1. Enroll 200 new patients through CCN, pre-natal program, outreach, and new site. B2. Cover safety, nutrition, parenting, growth/devel., etc.	B1. New patients and WCC visits are monitored by new MIS.	***B1. Well-child patients have increased from 156 in the entire previous yr, to 203 in the 1st 7 mos. of this contract year.***	***On course for a 123% increase in 1 year.***
C. Reduce incidences of lead poison scores >10 by 50%. (CHC)	C. Implement consistent lead testing and monitor follow-up.	C. Will be tracked by new MIS and automated clinical records.	***C. Lead Screenings are routinely conducted ages 2-6, but no data currently available (awaiting automated clin. Records)***	

IV. Problem/Need: Hypertension is a major health concern for adults in the service population, especially minorities. Hypertension leads to Cardiopulmonary Disease, and must be regularly monitored. Dietary and exercise behaviors must be consistently adhered to by patients.

Goals, Objectives, BPHC Funding Source	**Key Action Steps**	**Data Source/ Evaluation Method**	**Progress/ Outcomes**	**Comments**
A. Participate in research project of The Primary Care Institute to reduce risk of heart disease through intensified care of hypertension. (CHC)	A1. Utilize HS Tracker to implement 3-mo. Follow-up calls for all Hypertensive patients. A2. Continuing in-service for all practitioners on longitudinal BP management trends, home monitoring, medication subsidy & transportation resources. A3. Develop nurse-centered telephone BP management proto-cols to reduce unnec. Visits & improve personalization of care. A4. Make BP monitoring kits available for home use. A5. Provide transportation assistance when needed. A6. Assist patients in locating funding for needed medications.	A1. HS Tracker, Automated Medical Records. A2. Primary Care Institute will document all interventions. A3. PCI will document. A4. Accounting system will document # of kits purchased. A5. Accounting system.	A. ***Although the Center has not fully implemented the computer tracking of this project, manual chart audits have continued. Data was collected by the Primary Care Institute in January, 1999 but has not yet been analyzed. 379 patient charts were selected. Analysis due in May, 2000. Expected results: excellent continuity of care here.***	A complete research study involving two other primary care sites is the driving force for this project. 1992-97 data showed that the *Center* is more effective in providing care for African-American males than other participants.

V. Problem/Need: Drug and alcohol addiction is a major health concern for adults in the target population, contributing to mental health and physical disorders, addicted (NICU) infants, and crime, imprisonment and other deleterious social problems.

Goals, Objectives, BPHC Funding Source	Key Action Steps	Data Source/ Evaluation Method	Progress/ Outcomes	Comments
A. Help 70 addicted persons begin recovery. (CHC)	A. Continue CRS Outreach Program.	CRS Database	*CRS served 126 active clients in 1999-2000. 74% are not using drugs.*	
B. Help 100 recovering addicts remain continually free from drugs/alcohol	B. Continue CRS Outreach Program.	CRS Database	*164 clients of this program are not using drugs (self-report) as of 7/1/00.*	
C. Help at least 1 recovering woman deliver a healthy baby.	C. Monitor women in CRS who become pregnant.	CRS Database	*No pregnancies reported in current caseload.*	
D. Help 25+ recovering addicts secure housing, employment, and/or family reconciliation.	D. Contrinue CRS Outreach Program.	CRS Database	*From 7/1/99 - 6/30/00, 25 clients were helped to secure housing; 22 were helped to secure employment.*	

VII. The Homebound Elderly are a grossly underserved population. By providing regular nursing visits to high-risk Homebound Elderly, unnecessary hospitalizations and ER visits can be significantly reduced.

Goals, Objectives, BPHC Funding Source	Key Action Steps	Data Source/ Evaluation Method	Progress/ Outcomes	Comments
A. Provide more than 2,500 visits to a minimum of 250 high-risk homebound elderly patients.	A. Continue Homebound Elderly Outreach Program.	Now being tracked in Practice Management System.	*Provided 2,374 visits in calendar 1999 to 100 patients.*	
B. Prevent a minimum of 50 unnecessary hospitalizations.	B. Continue Homebound Elderly Outreach Program.	Will be documented monthly in Homecare reports.	*Documented interventions that prevented 20 hospitalizations.*	

East Liberty Family Health Care Center
BPHC Section 330 Community Health Center "New Start" Program
Business Plan

Note: Needs I-IV are addressed by the *Center*'s 1996 Strategic Plan. Needs I-II, V-VI are addressed by the *Center*'s 1999 "SMART" Plan.

I. Problem/Need: The need for additional clinical and administrative space, as well as administrative and clinical staff to relieve overcrowding at East Liberty Office and to reach out to more of the underserved and vulnerable in Pittsburgh' East End.

Goals, Objectives, BPHC Funding Source	**Key Action Steps**	**Data Source/ Eval. Method**	**Progress/ Outcomes**	Comments
A. Establish new office in Lincoln-Lemington.	A. Build/open 8-exam rm. Office.	N/A	*Patient volume in this office increased from 3,207 to 8,280 visits in past year.*	*This new office has been effective in helping us increase access to care.*
B. Renovate East Liberty Office.	B. Renovate offices for improved patient flow.	N/A	*Renovations completed 10/99 on schedule.*	*Added 1 Exam Rm, improved pat. flow.*
C. Add staff to increase capacity to serve more underserved patients.	C. Hire staff to operate two offices at full-capacity.	N/A	Full-staffing capacity achieved 3/23/99.	*Practitioner volume is steadily rising.*

II. Problem/Need: The need for a strong Administrative Infrastructure to undergird the clinical program of the *Center* in the rapidly changing managed care environment.

Goals, Objectives, BPHC Funding Source	**Key Action Steps**	**Data Source/ Eval. Method**	**Progress/ Outcomes**	Comments
A. Implement adequate financial staffing and internal controls to comply with BPHC standards.	A. Hire *Center*'s first Controller and Billing Specialist.	N/A	*New Controller hired 7/00. Blg. Spec. resigned 9/00. Exec. Serv. Corps. consultant recomms. Outsourcing.*	*Exec. Staff is reviewing outsourcing recommendation for decision by 01/01.*
B. Implement new Management Information System with Automated Clinical Records.	B1. Implement Billing/ Scheduling 7/1/98. B2. Imp. Clin. Records Phase I on 6/1/99.	N/A	*3 MDs began Auto. Clin. Rcds. on 6/00. Training for all others sched. for 10/00.*	*To be phased in over next two years—very time-intensive. Next phase-in: 01/01/01.*

Problem/Need: The need to respond in collaboration with other providers to achieve enough scale to effectively serve our population in the State-mandated Conversion of Medical Assistance to managed care.

Goals, Objectives, BPHC Funding Source	Key Action Steps	Data Source/ Eval. Method	Progress/ Outcomes	Comments
A. Establish Integrated Delivery System with 11 other agencies to represent >20,000	A. Form and launch Coordinated Care Network.	N/A	*Now includes 13 agcies, 5 PCPs, 3 FQHCs, 180+ programs. Implement-ing: 1. Pre-preventive primary care Program; 2. Educ./Outreach to agencies on MCOs. ->*	*3. Pharmacy for unins.; 4. Health Ins. For uninsured funded by cost savings from reduced hosp. admits; & 5. Blended care plan to address 7 disease-spec. health disparities.*
B. Participate in CCN to develop comprehensive network of care for underserved.	A. Participate in all Board and Committees.	N/A	*CCN is developing its Pat. Eval., Referral, & Treatment System (PERTS) information/referral system.*	*Pat. Eval., Referral, Treatment System (PERTS) purchased, being adapted for web-based access for all agencies.*

IV. Problem/Need: In order to support its planned expansion to serve more underserved persons, the *Center's* financial base must be expanded and diversified, moving away from reliance on non-renewable (primarily local foundation) forms of support.

Goals, Objectives, BPHC Funding Source	Key Action Steps	Data Source/ Eval. Method	Progress/ Outcomes	Comments
A. Launch 5-year Campaign to start-up new office, launch CCN.	A1. Hire full-time Dir. Of Development. A2. Raise $5m in 5 yrs.	Contribution Financial Reports (quarterly)	Dir. of Dev. Hired 10/96. *Campaign reached $4.5m 7/00.*	
B. Increase charitable annual giving by $50,000/year.	B1. Hire Dir of Dev. B2. Expand mailing list and regularize newsletters.	Contribution Financial Reports (quarterly)	Dir. of Dev. Hired 10/96. *Goal met for 1997-1999.*	
C. Decrease reliance on non-renewable sources.	C1. Inc. revs from insurers & and hosps. By 10%/year. C2. Establish Endowment for permanent rev. stream. C3. Apply for BPHC 330.	Contribution Financial Reports (quarterly)	*C1. Goal exceeded.* *C2. Patient Care Endowment will pro-vide $80,000 this yr.*	*C3. Approved and funded: 3/1/00.*

V. Problem/Need: The need to effectively reach out and communicate our mission to the underserved and unserved in our target area in order to attract new patients to use the *Center* for their primary care needs.

Goals, Objectives, BPHC Funding Source	Key Action Steps	Data Source/ Eval. Method	Progress/ Outcomes	Comments
A. Implement Quarterly Health Newsletters to surrounding residents.	A1. Implement.	Outreach Report to ED.	*8,000+ newsletters mailed to pts. & neighbors: 9/99, 1/00, 5/00, 9/00.*	*Featured new dental program, health choices.*
B. Annual (at minimum) personal contact with >20 churches/community orgs.	A1. Implement	Outreach Report to ED.	*We have changed this goal to cover phone or written contact and have met it.*	
C. Conduct at least 6 health outreach/ education events each year.	A1. Implement	Outreach Report to ED	*Since 3/1, our CRNP has run or attended 10 health education events.*	*Hypertension, Mammogrpahy, infant CPR, asthma, etc.*

VI. Need/Problem: The need for the *Center*'s staff to systematically evaluate internal processes for continuous improvement, to better serve patient needs.

Goals, Objectives, BPHC Funding Source	Key Action Steps	Data Source/ Eval. Method	Progress/ Outcomes	Comments
A. Create "Performance Improvement Team" as on-going vehicle for identification of systemic problems and proposals to correct.	A. Implement.	Quarterly Reports from Committee to ED.	*PIT folded into new Qual. Assur. Committee. !st Mtg: 9/24/00. To stress: credentialing & QA Risk Management. QA Plan being drafted.*	*Working w/ R. Dovolosky & S. Little to achieve 50% compliance & formalize existing QA practices.*
B. Improve patient flow/decrease patient waiting time.	A. Implement	Quarterly Reports from Committee to ED.	*2 of 3 proposals implemented, plus new phone system eliminated pt. Complaints re delays.*	*QA committee may re-implement pat. satis. Survey to confirm efficacy.*
C. Explore telephone router as means of better screening incoming calls.	A. Implement	Quarterly Reports from Committee to ED.	*Direct voice mails to practitioners eliminated need for auto router.*	*Telephone hold times of more than 1 min. virtually eliminated.*

Attachment C

EXPLANATION OF PROPOSED CHANGES IN THE CURRENT SECTION 330 HEALTH CENTERS AUTHORITY

Background

In the 35 years since their creation, America's Community Health Centers have proven their durability as a model health care program and their resilience in adapting to a dramatically changed American healthcare system while maintaining their original mission and purpose.

Health centers were established to provide access to quality preventive and primary health care for the medically underserved – including the millions of Americans without health insurance, low income working families, members of minority groups, rural residents, homeless persons, agricultural farmworkers, and those living with HIV or with mental health needs. Since their inception, health centers have served as a prototype for effective public-private partnerships, demonstrating their ability to meet pressing local health needs while being held accountable for meeting national performance standards. The success of the Health Centers program can be directly traced to the core elements found in Section 330 of the Public Health Service Act, its authorizing statute. These elements stipulate that each federally-supported health center must:

- Be located in, and serve, a community that is designated as "medically underserved," thus ensuring the proper targeting of federal resources on areas of greatest need;
- Make its services available to all residents of the community, without regard to ability to pay, and to make those services affordable by discounting charges for otherwise uncovered care to low income families in accordance with family income;
- Provide comprehensive primary health care services, including preventive care (such as regular check-ups and pap smears), care for illness or injury, services which improve the accessibility of care (such as transportation), and the effectiveness of care (such as health/nutrition education);
- Be governed by a board of directors a majority of whose members are active, registered patients of the health center, thus ensuring that the center is responsive to the health care needs of the community it serves.

In 1996, the Congress consolidated four separate targeted primary care programs (Migrant Health, Health Care for the Homeless, Public Housing health centers, and Community Health Centers) under a single authority, extending the consolidated program for five years. The new authority also included a limited new provision to fund health center-led networks and a new federal loan guarantee program. The consolidated Health Centers authority, at Section 330 of the Public Health Service Act, expires on September 30, 2001, and therefore requires reauthorization this year.

PROPOSED CHANGES TO SECTION 330 HEALTH CENTERS AUTHORITY

1. **Extension/reauthorization of Section 330 Health Centers authority for at least 5 years, at not less than $1.344 billion for FY 2002 and "such sums" for all future years**

Explanation

President Bush has publicly unveiled a multi-year plan to double the number of people served by health centers. More than 60 percent of Members of Congress have endorsed a similar plan. The Congress began that effort by providing $1.169 billion for FY 2001 for Section 330, a $150 million (15 percent) increase from the previous year. This year, a funding increase of at least $175 million will be needed to sustain and continue that effort. Under this plan, more than 10 million Americans will gain access to health center services in thousands of communities across the country.

2. Restoration of facility construction, modernization, and expansion as allowable uses of funds (both Planning/Development and Operational grants)

Explanation

Many health centers operate in facilities that desperately need renovation or modernization. In some cases, rapidly growing patient populations have strained the capacity of existing facilities—these facilities must be expanded. Other facilities are old, or inadequate for the efficient delivery of primary health care—these facilities must be modernized or replaced. A recent survey of health centers in 12 states found that almost two-thirds of them currently need to upgrade, expand or replace their current facilities. Moreover, many needy communities are not yet served by health centers—new facilities will have to be built (or existing facilities modernized, expanded or replaced) in order to extend health center services there.

However, most health centers have limited financial capacity to undertake needed facility improvements, expansions or new site development. Because health centers serve a large and growing uninsured patient base, operating margins are slim to non-existent for most health centers. That means that most health centers have only a very limited ability to support loans for their facility needs, and thus must rely on grants and charitable contributions. Yet, because they serve low-income individuals who generally cannot contribute significantly to capital campaigns, health centers have great difficulty raising charitable contributions.

At the same time, construction costs have soared in the strong economy. As a result, the gap between what health centers can afford and the cost of capital projects is growing. Restoring the government's ability to make grants for capital projects is critical to enabling health centers to maintain, modernize and expand their current facilities - or to replace old facilities or build new ones - to meet the growing demand for their safety net services.

3. Enhancement of current Loan Guarantee authority in Section 330 to cover facility loans

Explanation

Health centers' capital needs could also be more successfully met by enhancing the current federal Loan Guarantee authority in Section 330 -- which only permits the issuance of loan guarantees for managed care-related purposes -- to include loan guarantees for facility construction, modernization, and expansion, and for acquisition of facilities and equipment. In 1997 and 1998, Congress earmarked, out of appropriations made for Section 330, a total of $14 million for loan guarantees to 330-funded health centers, both for managed care purposes authorized under Section 330 and for capital purposes as authorized under Title XVI of the PHS Act (although Title XVI continues to exist in the PHS Act, Congress has not directly appropriated funding for Title XVI programs in years). Enhancing the current Loan Guarantee authority to cover facility loans would be consistent with Congressional intent to provide capital loan guarantees for health centers without having to appropriate funds against an otherwise dormant legislative authority, and would also permit other improvements to address shortcomings in current loan guarantee policy, including:

- **Allowing the guarantee to cover more than 80% (and up to 100%) of the outstanding principal amount** would allow lenders to price the loans at significantly lower interest rates by reducing the risk to them. Currently, OMB has determined that the federal loan guarantee for facilities can cover only 80% of the outstanding loan amount provided by a lender. Financial experts have stated clearly that partial guarantees are not sufficient to leverage capital at below-market interest rates, because lenders still perceive significant risk in these loans and fear that, in the event of default, they may not be able to collect even a small amount of the unsecured debt they financed.

- **Refinancing of existing loans** is currently not an eligible use for loan guarantee funds. If the refinancing results in significantly lower interest rates, the savings would benefit both the health center and the government. In addition, some health centers that have experienced financial difficulties are not able to obtain loan renewals from lenders without guarantees, severely limiting their use where they are most needed.

- **Permitting federal loan guarantees to be used with tax-exempt debt financing mechanisms** would allow health centers to access the lowest cost capital available to nonprofit institutions, benefiting both health centers and the government. Because the interest income from tax-exempt bonds is exempt from federal (and sometimes state) taxation, investors require lower returns on their

investments than would otherwise be the case for taxable investments. That tax-savings would translate into lower interest rates, allowing health centers to invest more of their operating resources into programs and services for vulnerable populations.

In combination with the restored capital grant authority discussed above, a revised loan guarantee program would be more effective in meeting the pressing capital needs of health centers.

4. Clarification of funding authority for networks at least majority controlled and, as applicable, at least majority owned by health centers funded under Section 330

Explanation

Health centers currently collaborate with each other, and with other community providers, in many different forms of networks and partnerships designed to improve access to and quality of care for their patients, especially uninsured patients. These include *practice management networks*, designed to improve quality through shared expertise (such as centralized pharmaceutical or laboratory services, clinical outcomes management, or joint management/ administrative services), to lower costs through shared services (such as unified financial or Management Information systems, or joint purchasing of services or supplies), or to improve access and availability of health care services provided by the health centers participating in the network. Most of these networks, once developed, need ongoing operational support to continue and further enhance their benefits. However, current law only authorizes support for the planning and development of managed care networks and plans. Expanding the types of health center-directed networks that can receive planning and development support, and allowing limited operational support for networks that are owned and/or controlled by Section 330-funded health centers, would substantially aid in achieving the health centers' mission and objectives.

5. Restoration of proportional funding allocation requirement for Community, Migrant, Homeless, and Public Housing Health Centers

Explanation

When four separate health center programs (Community, Migrant, Homeless, and Public Housing) were consolidated under a single Section 330 authority in 1996, the law included a requirement for allocating funds appropriated under Section 330 for each of the consolidated programs in accordance with the proportion of total funding they each had received in FY 1996. Despite the fact that this statutory funding allocation requirement expired in 1998, BPHC has continued to adhere to the methodology in distributing overall Health Centers funding among the Community, Migrant, Homeless, and Public Housing health centers. Vulnerable populations have benefited from BPHC's actions, and would be best served by restoring the original funding allocation methodology to the overall statute, thus ensuring the continued distribution of Section 330 funds to key underserved populations such as farmworkers, homeless persons, and public housing residents.

6. Clarification of eligible populations under Migrant and Homeless Health Center sub-authorities

Explanation

During consolidation of the health center authorities in 1996, coverage for formerly homeless individuals during the first 12 months following their transition to permanent housing was inadvertently dropped. Also, current authority fails to specify homeless youth as eligible for services, even though they remain a key homeless population. In addition, current law fails to recognize as eligible for services many farmworkers who, due to changes in agricultural employment, migrate for employment purposes but remain in farm work all year. Clarifying the eligibility of farmworkers employed on a year-round basis, as well as homeless youth and formerly homeless persons following their transition to permanent housing would ensure that the program remains appropriately targeted to the most vulnerable populations.

7. Clarification on provision of required services

Explanation

Under Section 330, all federally-supported health centers are required to provide or arrange for certain key health and related services, including medical, diagnostic lab and radiology, pharmaceutical, preventive dental, and patient case management services. Centers may also furnish additional services if needed by their patient populations, if resources are available.

Despite the statutory requirement, many health centers (especially newer centers and those serving rural communities) have not been adequately funded to support the provision of all required services. While this disparity has been reduced somewhat in recent years and may eventually be eliminated, and while the statutory requirement to provide comprehensive services remains a vital part of the health center model, clarification is needed to ensure that federally-supported health centers are expected "to the maximum extent practicable" to provide all required services, subject to available resources (both federal grant and other resources).

National Association of Community Health Centers, Inc.

EXPLANATION OF PROPOSED CHANGES IN THE NATIONAL HEALTH SERVICE CORPS STATUTE

Background

The National Health Service Corps (NHSC) plays a critical role in providing care for underserved populations by placing clinicians in urban and rural communities with severe shortages of health care providers. Currently 2500 NHSC clinicians, including physicians, dentists, nurse practitioners, physician assistants, nurse midwives, and behavioral health professionals, provide health care services to 4.6 million Americans, including 2.2 million Health Center patients.

While the NHSC program has proven successful in addressing health professional shortages in many areas, funding limitations have restricted the program's ability to meet its primary goal. According to HHS, more than 12,000 physicians would be needed to place sufficient providers in all health professions shortage areas (4 times the current number of NHSC providers), and more than 20,000 would be needed to bring all areas of the country to the same staffing ratios for providers that are used by both managed care organizations and Health Centers (8 times the current number of NHSC providers). The NHSC also needs to be streamlined to work more effectively with safety net providers, including Health Centers, which share the goal of improving health care access in underserved areas.

PROPOSED CHANGES TO NATIONAL HEALTH SERVICE CORPS AUTHORITY

1. **Reauthorize the National Health Service Corps for five-years at not less than $150 million for the first year and for such sums as are necessary for each subsequent fiscal year.**

Explanation

Although the NHSC's most recent reauthorization was for a ten-year period, most parties agree that five years is preferable this time. A five-year reauthorization demonstrates continued support for the purpose and role of the NHSC as a federal safety net program; provides for continuity in the administration of the program; and also allows for a more timely opportunity for Congress to review and make modifications in response to changes in the health care environment. The NHSC also warrants a substantial funding increase to address the significant need in designated underserved areas for NHSC Scholarship and Loan Repayment program recipients, and to support other critical activities such as site development, evaluation, faculty and student placement, retention incentives and research.

2. **Automatically designate all Federally Qualified Health Centers and Federally Certified Rural Health Clinics that meet the accessibility and affordability requirements (above) as Health Professional Shortage Area (HPSA) facilities.**

Explanation

The NHSC and the Health Centers Programs are intended to address the same goal (to meet the health care needs of underserved populations) and are administered by the same federal agency, the Bureau of Primary Health Care. Requiring a health center to obtain a Health Professional Shortage Area (HPSA) designation, even though each health center already serves a "medically underserved area or population" creates a bureaucratic hurdle to placement of NHSC personnel at health centers. Providing automatic HPSA facility status to health centers and rural health clinics, thus making them eligible for placement of NHSC personnel, will reduce bureaucratic barriers and allow coordinated use of federal resource in meeting the health care needs of areas that lack sufficient health care services.

3. Eliminate duplication of effort in the placement of NHSC personnel.

Explanation

After completing their taxpayer-funded medical education, many NHSC Scholars request -- and HHS often approves -- a waiver of their NHSC service obligation if they agree to establish a "private practice option (PPO)" in a designated HPSA. In most such cases, the Scholar is free to practice in virtually any HPSA (whereas those who fulfill their service obligation through assignment are targeted to high-need HPSAs). Currently, these "private practice option" clinicians are not subject to the requirement that they open their practice to all in the community regardless of ability to pay; and, in some cases, these NHSC-subsidized for-profit practices have been found to resist caring for uninsured – and even Medicaid-covered – patients, instead referring them to nearby health centers and other local safety net providers. Congress should remedy this by restricting PPO placements to HPSAs that are not currently being served by a health center or rural health clinic, except where the PPO clinician is placed at the center or clinic.

4. Ensure fairness in priority consideration for NHSC placements.

Explanation

While intended to ensure that all Corps placements were made in areas of highest need, the current criteria used to determine whether a site is included on the high priority placement list has actually had the effect of discriminating against health centers and other similar entities, because it severely restricts the Secretary's flexibility to consider certain factors as indicators of need, including documented access barriers such as linguistic or cultural isolation, transportation barriers, and other factors highly correlated with underservice – such as large uninsured, elderly, disabled, or minority populations. Thus, an area or population distinguished by the above-noted characteristics, but with a relatively low infant mortality rate or what appears to be an adequate supply of health professionals, for example, would be penalized by being deemed a low priority for the placement of a new NHSC assignee.

5. Establish due process rights in cases of HPSA de-designations and priority list development.

Explanation

Under current law, the Secretary is required to notify interested organizations and individuals in an area of that area's de-designation as a HPSA, but is not required to follow the same procedure in the case of a population group's or facility's de-designation. Furthermore, while current law requires the Secretary to publish annually list of priority placement sites for new NHSC assignments, it does not require notice to entities that are not included on the list, nor does it provide any due process rights to such entities to provide supplemental information or to file an appeal of their exclusion. Such due process rights are a central part of many other statutes, and should be included in the NHSC law, particularly in view of the consequences of the loss of HPSA designation or priority status to areas that had previously been considered high-priority shortage areas.

6. Allow NHSC scholarship and loan repayment program recipients to fulfill their commitment on a part-time basis. This option would only be available if such service is agreed to by 1) the placement site or sites as well as the scholarship and loan repayment recipients and 2) so long as the total obligation is fulfilled.

Explanation

Flexibility should be provided to enable Scholarship or Loan Repayment program recipients to complete their service obligation on a full-time or part-time basis, with the approval of the placement site. Many small rural communities may not have sufficient volume to support a full-time health care practitioner. In addition, some sites may not need particular types of providers on a full-time basis. Flexibility should be given to the Department to permit part-time service in meeting community needs. In addition, some practitioners may find part-time service more attractive, which in turn could improve both recruitment and retention at these sites.

7. Include a specific allocation for site development and community needs assessment.

Explanation

The NHSC was created to meet the needs of communities that lack access to health care services. In many cases, those shortage communities require physical, oral, and mental/behavioral health care services. Over the years, the NHSC has recognized that each community has unique health needs and has placed a wide variety of health professionals in sites to meet those needs. However, many believe that the NHSC needs to dedicate additional resources to inform and educate communities about the variety of placement opportunities provided by the NHSC, and to assess the real health care needs of communities that are applying for placement of personnel. In order to ensure that communities receive the maximum benefit from the program, the NHSC should allot adequate resources to inform communities of the variety of health care resources available through the NHSC and how those resources can best be used to meet the unique health needs of communities, in collaboration with those communities and other health partners.

8. Assist communities and sites in developing incentives to support the retention of NHSC providers beyond their obligation.

Explanation

Many current and former NHSC recipients have expressed concerns about professional isolation and burnout during their term of obligated service. While most initially declare their intent to remain after completing their obligation, many change their minds by the time their assignments are completed. In many communities, the NHSC recipient may be the only health care professional. As such, they are "on" 24 hours per day, 7 days per week. Providing scheduled breaks for professional development or personal time will increase the likelihood that recipients will remain in these communities beyond the period of their assignment. Examples of incentives might include support for locum tenens, mini-sabbaticals, continuing professional education, and increased practice management technical assistance for current scholarship and loan repayment recipients.

9. Eliminate the community cost-sharing provision (Section 334 of the Public Health Service Act).

Explanation

Section 334 of the Public Health Service Act ("Cost Sharing") requires that an entity to which a member of the NHSC is assigned must reimburse the Federal government for the cost of that NHSC member. In practice, this requirement is waived in almost all cases. In 1998, the cost-sharing requirement was waived in at least 95% of cases and the cost of collecting the remaining 5% of payments exceeded the funds received. This provision should be eliminated because it creates an undue burden on communities (which are economically unstable by definition) in seeking an NHSC clinician, and it poses an unnecessary administrative burden on the NHSC. Clearly, these dollars could be better used in providing access to care. This action is consistent with the spirit of the Paperwork Reduction Act and will facilitate increased usage of NHSC' clinicians by underserved communities.

10. Require all NHSC Scholarship and Loan Repayment recipients, as well as all NHSC placement sites, to (1) serve all residents regardless of ability to pay (2) bill and collect from third party payers for care furnished to covered individuals and (3) discount normal charges for out-of pocket costs based on ability to pay.

Explanation

Section 334 (repealed above) included language requiring that Corps personnel "...to the maximum extent feasible, provide...services...to all individuals in, or served by, such HPSA regardless of their ability to pay for services...." These provisions need to be retained elsewhere in the NHSC statute and to be clarified to reinforce the principle that a vital purpose of the NHSC is to reduce access barriers for everyone living in communities lacking health professionals, regardless of their income or ability to pay

for services. In addition, language is needed to require DHHS to monitor this requirement to determine whether Corps personnel and their sites are actually meeting these requirements and to enforce compliance.

Related Recommendations:

1. **Exclude from Federal income, FICA, and self-employment taxation tuition, fees and related educational expenses to individuals participating in the NHSC Scholarship, Loan Repayment, Community Scholarship and State Loan Repayment program (group with other retention provisions).**

Although this falls under the jurisdiction of other Congressional Committees, and must therefore be moved through separate legislation, all parties agree with the NHSC and the NHSC Advisory Council that taxing students adversely affects the financial incentive to participate in the NHSC and provide health care services in underserved communities, many of which are frontier communities.

Mr. BILIRAKIS. Thank you so much, Mr. Brewton, that is quite a story.

Mr. Singer, please proceed, sir.

STATEMENT OF JEFF SINGER

Mr. SINGER. Mr. Chairman, ranking member, members of the audience, my name is Jeff Singer. I am the President and CEO of Health Care for the Homeless of Maryland. I am also here as the Policy Chair of the National Health Care for the Homeless Council, and I am joined by our distinguished Executive Director, Mr. John Lozier, as well as our Health Policy Analyst, Bob Reed, who has done an enormous amount of work on these reauthorization issues, and we thank Bob for that.

I am also here representing some folks who couldn't be here. Willie, the merchant seaman, who is bound to his wheelchair by a head injury, and spent the last winter on the streets of Baltimore in that wheelchair because there is no shelter that is handicapped-accessible; Harold, the coalminer from West Virginia, who had been sleeping in an abandoned Merdeces Benz, wrapped only in his depression and his alcoholism; John, Mary, and their daughter, Dreesen, stranded in Baltimore when their car broke down on their way from their old home in Oklahoma to their new job in Connecticut, without the money for health insurance, their savings eaten away by a motel.

Homelessness is harmful to people's health. It causes health problems—the infections on Willie's back from being in the wheelchair 24-hours-a-day. It exacerbates health problems—Harold's cold turned into pneumonia, sleeping in a car in the winter. And it complicates treatment. Where does the homeless person with diabetes store her insulin and syringes?

Fortunately, there is an effective Federal program to address this program, and that is the Health Care for the Homeless Program, one of the four Community Health Center programs run by the Bureau of Primary Health Care. It provides the resources to 137 Health Care for the Homeless Programs in every State, in the District of Columbia, and in Puerto Rico, to provide a comprehensive array of services enabling us to go out on the streets, to get people off of the streets, and back into the mainstream.

These 137 programs last year served 500,000 different people. Unfortunately, that is only about a seventh of our friends, neighbors and relatives who are experiencing homelessness, and yet we provide very significant services. Sixty percent of the people we see are men, and men tend to be uninsured at higher rates than women and, in fact, 73 percent of the people served were uninsured. Sixty percent were members of minorities, and 15 percent were actually children.

This is an effective program, and it is a program that, in part, is represented by the National Health Care for the Homeless Council. The Council is a membership organization. It provides technical assistance in education to homeless health care providers around the Nation, but it also is interested in public policy. We recently heard the Secretary of the Department of Housing and Urban Development, Secretary Martinez, say, "After $10 billion spent on homeless services, why does homelessness persist?" It is a very important question and, in fact, it has a relatively simple answer. Until all Americans have the right to health insurance and adequate health care, until we have a sufficient supply of affordable housing, and until incomes permit people to live with dignity, whether people are working and earning a living wage, or disabled and receiving disability assistance that permits them to purchase housing, until these things happen, homelessness will persist. But until they happen, we are very happy to have a Health Care for the Homeless program that reaches out to people who need help.

In Maryland last year, we served 9,000 different people. We had 45,000 patient encounters. In the 16 years in which we have been in operation, we have assisted more than 70,000 different people. We provide comprehensive care—that includes medical care, mental health services, we are a certified outpatient addiction treatment center, and social work services as well. We are the first independent Health Care for the Homeless program to be certified by JCAHO, the Joint Commission on the Accreditation of Health Care Organizations, so we try to meet the highest quality standards, but it is a very difficult challenge. It is difficult in part because the costs keep rising. We pay 30 percent more for prescriptions this year than we did last year, and we haven't heard of any prescription initiatives in Congress this year that will address our problem because it is not people who are elderly, it is ordinary Americans.

The nursing shortage has affected us. We have lost five nurses this year to hospitals because they pay a lot more money than we can. But these challenges can be met with your help.

We are very supportive of the reauthorization of the program at the highest level as possible. There are particular issues that we call to your attention. One is to maintain the proportionality of the distribution of funds. Health Care for the Homeless programs receive 8.6 percent of the Community Health Center funds, and we would like to keep it that way, and there is universal support for that.

We would also like to be able to serve people who have been housed for 12 months after they have left the streets. We used to be able to do that, but the reauthorization in 1996 eliminated that capacity and we would like to have it again. And we would like to expand the definition of addiction programs to include the out-

patient treatment that most of us can provide. And we would like to be sure that youth are included as a target population.

I thank you very much for your assistance. The stories I told you in the beginning all had good endings. Willie is now in a wheelchair and we delivered a television to him the other day. Harold, after 5 years we were able to get him Medicaid and SSI. He had an apartment. He listened to his country music and ate his scrapple and cleaned up the florist shop around the corner. And John and Mary, their daughter recovered. John found a job and, in fact, he became a Legislative Aide to Congressman Elijah Cummings of Maryland's 7th District. We can make a difference and, with your help, we will. Thank you.

[The prepared statement of Jeff Singer follows:]

PREPARED STATEMENT OF THE NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL

INTRODUCTION

The National Health Care for the Homeless Council (the National Council) is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. The National Council works to improve the delivery of care to people experiencing homelessness, and to reduce the necessity for dedicated health care for the homeless programs by addressing the root causes of homelessness. Our organizational members receive funds through the federal Health Care for the Homeless (HCH) Program. The HCH program is part of the Consolidated Health Centers account of the Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services.

Our statement covers the following points:

- explanation of the intersection of health and homelessness;
- review of the success of the federal government's primary policy response to the immediate health services needs of people experiencing homelessness—the HCH program;
- discussion of the challenges facing HCH projects, including increasing demand and decreasing services;
- recommendations for reauthorizing and strengthening the HCH program;
- recommendations for reauthorizing and strengthening the Community Health Center (CHC) program;
- recommendations for reauthorizing and strengthening the National Health Service Corps (NHSC) program; and
- comments on the Community Access Program (CAP).

Before we begin, the National Council expresses its profound regret that there is still a need for discussion in this day and age about health care access barriers facing poor people and people without insurance. It is tragic that our nation continues to fail to guarantee access to health insurance as a fundamental right for every American. Ultimately, Americans' health care access challenges, including those facing people without stable housing, must be redressed through a universal health care system. We favor a single-payer mechanism.

Yet even universal health insurance would not preclude the need for HCH projects. The abdication of public responsibility for affordable housing is a two-decade long tragedy that is the fundamental factor perpetuating homelessness. Until our nation invests in a housing stock sufficient for and affordable to all of our neighbors, the economic, social, and human costs of homelessness will mount.

HEALTH AND HOMELESSNESS

Poor health and lack of access to health care are among the causes of homelessness. For people struggling to pay for housing and other needs of daily living, the onset of a serious illness or disability can easily result in homelessness following the depletion of financial resources.

Homelessness is a health hazard. The experience of homelessness causes poor health, exacerbates existing illness, and seriously complicates treatment. Conditions such as frostbite, leg ulcers, and respiratory infections are a direct result of living on the street. Homelessness precludes good nutrition, good personal hygiene, and basic first aid. People without a regular place to stay are also at great risk of emotional trauma due to familial estrangement, multiple losses, and the chaos of an

itinerant lifestyle. Children and youth are particularly affected by the chaos of homelessness with greater risk of childhood depression, malnutrition, immunization delay, repeated infections, developmental delay, and discontinuity of school/learning experiences. People without a regular place to stay are also at greater risk of physical and emotional trauma resulting from muggings, beatings, and rape. Conditions that require regular, uninterrupted treatment, such as tuberculosis, HIV, diabetes, hypertension, addiction, mental illness, and pregnancy are extremely difficult to treat or manage in the absence of a stable residence.

The consequences of restricted access to comprehensive health care are reflected in extremely high rates of both chronic and acute health problems among people experiencing homelessness. The Institute of Medicine has determined that those without a regular place to stay are far more likely to suffer from most categories of chronic health problems in comparison to the general population.[1] Research also demonstrates that the cost of acute care for people experiencing homelessness is significantly higher than for the general population.[2]

Access to appropriate treatment and care is hindered dramatically by a lack of a national health care system. National data gathered by the HCH program[3] reveals that 73 percent of HCH patients have no source of health insurance. Inaccessible public transportation, inflexible clinic hours, fees and payments, and residency and documentation requirements may also present barriers to health care.

HEALTH CARE FOR THE HOMELESS PROGRAM

Origins and Current Status

The first federal response to the crisis of homelessness was the passage of the Stewart B. McKinney Homeless Assistance Act of 1987. *Recognizing that homelessness restricts access to mainstream health care services, Congress established through the McKinney Act a health services program specifically designed to circumvent these barriers—Health Care for the Homeless (HCH).* The federal program extended the success of an earlier Robert Wood Johnson/Pew Charitable Trusts program, which demonstrated that health care services specifically targeted to people experiencing homelessness could dramatically improve access to care for this vulnerable population.

Congress last reauthorized the HCH program in 1996 via the Health Centers Consolidation Act. That law consolidated community health centers, migrant health centers, public housing primary care centers, and HCH projects under a single, five-year authorization, but retained each of the four programs as a distinct activity. Authorization of the consolidated health centers account expires in September 2001.

Program Summary

The HCH program (Section 330(h) of the Public Health Service Act [PHSA]) makes grants to community-based organizations (referred to as "projects" or "grantees") in order to assist them in planning and delivering high-quality, accessible health care to people experiencing homelessness. *HCH projects assure access to primary care and related services through integrated systems of care.* Projects provide primary health, mental health, addiction, and social services with intensive outreach and case management to link clients with appropriate services.

Formal evaluations of the HCH program, including a 1995 evaluation conducted for the Department of Health and Human Services, indicate that the projects are meeting the health care and support service needs of people experiencing homelessness—at levels that are unprecedented in the mainstream indigent health care and public health insurance systems.

Eligible Population

Projects are required to use their HCH funds to serve people experiencing homelessness, who are defined in the PHSA as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing."

In 1999, HCH projects served nearly 500,000 patients. 59 percent of patients were male; 41 percent female. 60 percent were people of color. 15 percent were children and youth under age 19.

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[1] Institute of Medicine. "Homelessness, Health and Human Needs." 1988.

[2] National Health Care for the Homeless Council. "Utilization and Cost of Medical Services by Homeless Persons: A Review of the Literature and Implications for the Future." April 1999.

[3] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care, Uniform Data System (UDS) Report for Fiscal Year 1999.

Eligible Projects

HCH projects are initiated, designed, and managed at the community level. Any local public or private, nonprofit entity is eligible to apply for HCH funds, including freestanding nonprofit community-based and faith-based organizations, community health centers, hospitals, local health departments, shelters, and homeless coalitions.

The HCH program currently funds 137 grantees in all states, the District of Columbia, and Puerto Rico. 50 percent of projects are sponsored by community health centers. Public health departments sponsor 19 percent. 25 percent are sponsored by private, nonprofit organizations, and the remaining six percent are sponsored by hospitals.

Required Services

HCH projects, like other health centers, are required to provide the following health and enabling services:

- basic health services related to family medicine, internal medicine, pediatrics, obstetrics, and gynecology;
- diagnostic laboratory and radiologic services;
- preventive health services, including prenatal and perinatal screening; screening for breast and cervical cancer; well child services; immunizations against vaccine-preventable diseases; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; voluntary family planning services; and preventive dental services;
- emergency medical services;
- pharmaceutical services;
- referrals to providers of medical services and other health-related services;
- patient case management services (including counseling, referral and follow-up) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, educational, or other related services;
- services that enable individuals to use the services of the health center (including outreach, transportation, and translation);
- education of patients and the general population served by the health center regarding the availability and proper use of health services; and,
- addiction services.[4]

In addition, most HCH projects surpass this scope of services. For example, many HCH projects offer mental health services to their patients. Others have secured resources from other federal programs, state and local government, and the nonprofit and private sectors to develop housing for their patients.

Service Delivery Locations

HCH service delivery sites vary by project, but include fixed-site health clinics, services provided at homeless shelters and soup kitchens, mobile medical units, and street outreach teams. Services are provided either directly, by contract with other organizations, or by referral to another organization.

Award Process

HCH funds, like funds for other health center programs, are distributed via a competitive award process. Applications for HCH funds are reviewed by an independent expert panel consisting of HRSA staff and outside experts. The applicant must:

- describe the target population;
- demonstrate the target population's health services need;
- outline a plan to provide the health services required by the Consolidated Health Centers law; and,
- agree to a number of requirements that are a condition for receiving funds.

Those conditions include:

- establishing a governance body that includes significant participation from consumers of the health services offered by the project, including people who are experiencing or who have experienced homelessness;
- making the statutorily-required primary health services available and accessible promptly, as appropriate, and in a manner which assures continuity;
- establishing and maintaining relationships with other health care providers;

[4]This required service is unique to HCH projects. Other health centers are not required to provide addiction services.

- developing an ongoing relationship with at least one hospital;
- having an arrangement with the State Medicaid agency to be reimbursed for health services provided to Medicaid beneficiaries;
- making every reasonable effort to collect appropriate reimbursement for health services provided to people entitled to public or private health insurance;
- establishing a schedule of fees or payments for the provision of services and a schedule of discounts based on a participant's ability to pay;
- having an ongoing quality improvement system; and
- developing a plan, budget, and data collection system.

Appropriations

In FY 2001, Congress appropriated $1.169 billion for the consolidated health center account, which amounted to $100 million for the HCH program.[5]

CHALLENGES FACING HCH PROJECTS

The fundamental challenge facing HCH projects—as well as all health centers and other health care safety net providers—is one of insufficient resources to sustain and expand services to people with limited or no means to pay for health care.

The failure to appropriately invest in the nation's health care safety net prevents HCH projects from fully responding to the following dynamics among and needs of people without stable housing.

Increasing Homelessness—As an increasing number of people have incomes that fall below federal poverty guidelines and find themselves living with friends, relatives, in shelters and the streets, more people are seeking services from HCH projects. Among the new patients of HCH services are families with children exiting the welfare system, people with disabling addictions who have been denied access to Medicaid and Supplemental Security Income, "working poor" individuals whose earnings are insufficient to afford housing or health insurance, emancipated and unaccompanied youth, and veterans unable to obtain Department of Veterans Affairs health services. *HCH projects do not receive sufficient funds to adequately serve their current caseloads, much less address the increased demand for services from these emerging homeless subpopulations.*

Financial Distress of HCH Projects—Many HCH projects report decreasing revenues, especially from Medicaid. The enrollment of Medicaid beneficiaries in managed care organizations has resulted in a dramatic decrease not in the number of Medicaid beneficiaries served by HCH providers, but in the reimbursements received from Medicaid. Consequently, HCH projects have been forced to use federal grant and other funds now designated for services to uninsured patients to balance the cost of care for Medicaid patients, thereby reducing or eliminating services for patients who lack health insurance. *HCH projects do not receive sufficient funds to adequately serve both their Medicaid and uninsured patients.*

Untreated Addiction and Mental Illness—HCH projects are required by statute to provide access to addiction services. Many also provide mental health services. *Regrettably, inadequate funding levels have prevented many projects from providing such services at more than an elemental level,* even though projects report that that addictions and mental illnesses are among the most prevalent diagnoses of their patients. Mainstream addiction and mental health services programs are also underfunded and oversubscribed, and are also not designed appropriately for people in homeless situations, further restraining willing homeless patients from accessing treatment for these chronic conditions. *HCH projects do not receive sufficient funds to adequately meet their patients' comprehensive health services needs.*

Lack of Supervised Medical Care for People in Recuperation—In the absence of a safe place in which to recuperate from illness, medical interventions often prove ineffective for people experiencing homelessness. The unavailability of appropriate accommodations for those requiring supervised medical care, but not ill enough to remain hospitalized, makes it difficult for individuals to recover from illness and resolve their homelessness. Several HCH projects have pioneered responses to this service gap in the form of medically-supervised "recuperative care." *HCH projects do not receive sufficient funds to develop or expand recuperative care arrangements for patients in desperate need of such services. In most communities, there is no other source of funding to pay for recuperative care services to people experiencing homelessness.*

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[5] The HCH program customarily receives 8.6 percent of the total consolidated health center appropriation, consistent with the portion allocated to it by Congress in the first year of authorization in the Consolidated Health Centers Act

REAUTHORIZE AND STRENGTHEN HEALTH CARE FOR THE HOMELESS PROGRAM

The HCH program, the statutory authority of which expires September 30, 2001, is still needed to ensure access to health services for people experiencing homelessness. *We urge Congress and the Administration to reauthorize HCH for a five-year period as a distinct program within the Consolidated Health Centers account.*

In addition, we urge Congress and the Administration to amend the HCH statute as follows:

- **Establish an authorization level** of at least $172 million in FY 2002 as part of a $2 billion FY 2002 authorization level for the Consolidated Health Centers account.
- **Maintain current distribution** of Consolidated Health Centers appropriations among component programs within the account.
- **Restore ability of HCH grantees** to temporarily continue to provide services to their formerly homeless patients.
- **Expand range of addiction services** that HCH grantees may provide to include harm reduction, outpatient treatment, complementary modalities, and rehabilitation, in addition to detoxification and residential treatment.
- **Explicitly identify homeless youth** as an eligible target subpopulation for innovative homeless children outreach and comprehensive primary health services grants.

REAUTHORIZE AND STRENGTHEN COMMUNITY HEALTH CENTER PROGRAM

Mainstream indigent health care programs have historically underserved the homeless population. Congress recognized this reality and established the HCH program. Due to funding limitations, however, the HCH program is able to serve only about 1/7 of the population estimated to experience homelessness each year. *Consequently, a majority of people experiencing homelessness relies on mainstream indigent health care providers, including community health centers, for their health care.*

Just as they do in other mainstream indigent health care systems, people experiencing homelessness face multiple challenges in accessing and utilizing community health centers. For example, the General Accounting Office, in a 2000 report (*Homelessness: Barriers to Using Mainstream Programs,* GAO/RCED-00-184), found that community health centers: 1) may not be organized to make some of the special accommodations homeless people may require, such as walk-in appointments; 2) may not thoroughly address other needs that are inextricably linked to a patient's health care needs, such as housing, food, clothing, and other services; 3) do not tend to outstation health services at locations and settings where homeless people congregate. Denials of or delays in service based on inability to pay have also been reported.

To redress the barriers that people experiencing homelessness are facing in accessing and using community health center services, we urge Congress and the Administration to amend the health centers statute as follows:

- **Require community health centers to develop outreach and services plans for the homeless population** to ensure that community health centers factor the complex medical and social needs of people experiencing homelessness into their service system design and implementation in anticipation of the inevitability that people without housing will be seeking care from them.
- **Ensure access to health center services regardless of ability to pay** by codifying in statute the long-standing principle that health center services are to be available to patients regardless of their ability to pay and by restoring provisions of prior law that assured that extremely poor people would not have fees or payments imposed on them.
- **Ensure that health centers provide assistance in obtaining housing** in parity with current law requirements that they assist their patients in obtaining other public benefits (e.g., Medicaid, Food Stamps).
- **Add addiction and mental health services as optional additional services** to encourage all health centers to expand their scope of services to include treatment for these chronic conditions to the extent practicable.
- **Add recuperative care as an optional additional service** to encourage all health centers to expand their scope of services to include this service to the extent practicable.

REAUTHORIZE AND STRENGTHEN NATIONAL HEALTH SERVICE CORPS PROGRAM

The National Health Service Corps (NHSC) program, the statutory authority of which has expired, is still needed to ensure that Health Care for the Homeless projects and other safety net providers are able to recruit and retain the health

services professionals necessary to operate their programs. *We urge Congress and the Administration to reauthorize the NHSC for a five-year period.*

In addition, we urge Congress and the Administration to amend the NHSC statute as follows:

- **Establish an authorization level** of at least $232 million in FY 2002 for NHSC.
- **Automatically designate all federally-qualified health centers,** including Health Care for the Homeless projects, **as Health Professional Shortage Area facilities** for placement of Corps personnel.
- **Ensure access to health services provided by NHSC professionals regardless of the patient's ability to pay** by codifying in statute that services provided by entities with NHSC placements and NHSC private practice option placements are to be available to patients regardless of their ability to pay and by waiving or reducing charges for people who are unable to pay.

RECOMMENDATIONS ON COMMUNITY ACCESS PROGRAM

Health Care for the Homeless projects share the common belief among health care safety net providers and public officials that patients derive improved health and other benefits and that the health care safety net system operates more efficiently when collaboration occurs among disparate providers serving the same people. *As the principal health care safety net providers to people with the most complex and interrelated medical and social conditions possible, HCH projects have had to foster collaboration among health, housing, and support service providers in their communities. For HCH projects, collaboration and linkages are intuitive processes.*

The National Council has neither supports nor opposes authorization of the Community Access Program or equivalent initiatives. Our members' views on this topic differ. Some HCH projects believe that *new federal safety net health care resources should be directed to the support of services rather than to interactive functions.* Other HCH projects have reported positive collaborative experiences that are occurring in their communities as a result of CAP projects.

Should Congress choose to authorize CAP or an equivalent health care safety net collaboration program, we recommend that the following principles guide the program's development.

- The program should facilitate improved and expanded access to a full range of health and support services for all people without health insurance, with a focus on those hardest to ensure or hardest to serve.
- Funds should be directed to health and support service access improvement and expansion rather than to the establishment of planning and collaboration infrastructure.
- Applicants should be permitted to propose population-focused projects (e.g., improving access to targeted, disproportionately affected and historically underserved groups, such as homeless, migrant, or youth) as well as geography-based projects (e.g., improving access to all people in a given service area).
- Funds should be permitted for both individual level and system level service interventions. Examples of individual level interventions include outreach and engagement, public health insurance assistance and advocacy, patient case management, and direct payment for services. Examples of system level interventions include system integration, care coordination, and patient record exchange.
- Grantees should be the community-based primary health provider or network of providers that is most closely connected to the intended beneficiaries. Primary health providers are the most appropriate, and most common, gateways to other health and support services. They are also key players in treating patients and addressing their basic health needs before they present at emergency and specialty care providers.
- As a condition for receiving funds, grantees should be expected to demonstrate collaboration with other health care safety net providers in the community, such as community, migrant, homeless, and public housing health centers, public and charitable hospitals, local public health departments with service delivery components, free clinics, academic health centers providing uncompensated care, addiction service providers, mental health service providers, HIV/AIDS service providers, and family planning clinics.
- The scope of health systems, programs, and providers that should be involved in community collaboration include primary, addiction, mental, HIV/AIDS, maternal and child, oral, vision, emergency, and other secondary and tertiary health services.
- Community collaborations resulting from the initiative should include support systems, programs, and providers (such as housing providers) that are essential to the effective delivery of health services to intended beneficiaries.

• Representatives of intended beneficiaries should be involved at the community level in need identification, project design, and implementation monitoring.

Mr. BILIRAKIS. Thank you, Mr. Singer.

Ms. Monson.

STATEMENT OF HON. ANGELA MONSON

Ms. MONSON. Good morning, Mr. Chairman, Mr. Brown and other distinguished members of the committee. I am very happy to be here with you again today, and I promise I won't have to leave early. I will be here as long as you need me today, Mr. Chair.

My name is Angela Monson. I am a member of the State Senate in Oklahoma where I chair the Senate Finance Committee. I have the pleasure today of representing the National Conference of State Legislatures, where I serve as Vice President, soon to be President-elect, in 1 year President of that great organization. I also have the privilege of serving as Chair of the National Advisory Council to the National Health Service Corps. And I also want to note that I got my start in health care policy as a board member of the Mary Mahoney Community Health Center more than 20 years ago, in the eastern part of my Senate district, so I am very pleased to be here with you to talk about, I think, is one of the most important subjects facing the United States today, and that is health care, health care access, and why should the National Conference of State Legislatures pass a policy endorsing and encouraging and promoting the reauthorization of the National Health Service Corps, therefore, my remarks today will primarily be geared in that direction, but do know we support the continuation and expanded funding of the Community Health Centers.

I have had the pleasure of supporting and authoring legislation in Oklahoma that has provided a substantial amount of money to our Community Health Centers, State money to our Community Health Centers.

We realize that President Bush's proposal and the support received for the expansion of the number of Community Health Centers will be good, it will do good, but it will also place a greater burden on the need for clinicians in underserved areas. The National Health Service Corps stands ready to meet that need. It is important that we recognize that the value of the National Health Service Corps does extend beyond the value to those clinicians that receive an opportunity to serve and those individuals who receive health care services, but truly impact the true nature of communities. The substantial change in communities as a result of these services provided truly last a lifetime.

It is important also to recognize that the National Health Service Corps provides an opportunity to meet the culturally diverse needs in our communities. The Corps facilitates the placement of practitioners that look like the communities in which they serve. They provide the kind of cultural competency that is necessary to ensure that health status is improved.

I would like to spend just a few minutes, however, making some comments on recommendations that focus on changes in ten National Health Service Corps that I think are important to improve the benefits of that program. First of all, increased funding. I think we all are aware that although the National Health Service Corps

does a wonderful job in providing clinicians in underserved communities, there is a huge demand, a great need, that is unmet, and that need will only be met if we are able to increase the number of clinicians that are provided to these communities. That means additional dollars.

The Loan Repayment Program is an excellent program. We are aware of the articles that were written last year about problems with clinicians in communities. That problem could have been addressed with additional revenue, with our ability to place more loan repayers.

The Scholarship Program, which is an excellent program in terms of recruiting and retaining clinicians who otherwise would not be given the opportunity to enter into health care professions need additional revenue. There is a demand there that we cannot meet with the current funding levels.

Two other areas I would like to mention, greater flexibility in the National Health Service Corps Program. Greater flexibility helps meet community needs. It helps communities identify what they really need, where those services must be provided, how those services should be provided, but flexibility, increased flexibility, is important so those particular community needs might be met.

It is important also that we create flexibility in the program to meet the needs of participating providers to allow clinicians to serve in situations that require less than full-time service. It is important that we also continue to look at necessary tax relief, particularly for the Loan Repayment Program.

Thank you for addressing the issue in our Scholar Program last year, but it is also an issue that must be addressed in the program across the board.

Let me simply summarize to you by encouraging you to continue to provide this kind of attention, this kind of guidance and leadership in the area of health care. States have entered into the arena of attempting to provide services and coverage for many uninsured and underinsured citizens. However, we cannot do it alone. It is a partnership. And as we continue to expand coverage opportunities, the need for clinicians for these underserved and uninsured populations will even become more evident.

Let me encourage you that as you look at the CAP program and the National Health Service Corps and the Community Health Centers Programs and new initiatives to meet clinician needs the needs of communities, that we focus on coordination of programs. The need is great. Coordination of activities and policies is fundamental if we are going to create the kinds of efficiencies and revenue.

Truly, the health of our country is dependent upon the actions taken in our State Legislatures and the actions taken by you. So, I encourage you to, for the health and well being of our country, to take the appropriate action. I thank you for listening today.

[The prepared statement of Hon. Angela Monson follows:]

PREPARED STATEMENT OF HON. ANGELA MONSON, OKLAHOMA STATE SENATE, VICE-PRESIDENT, NCSL ON BEHALF OF THE NATIONAL CONFERENCE OF STATE LEGISLATURES

Chairman Bilirakis and distinguished members of the subcommittee: My name is Angela Monson. I am a state senator in Oklahoma where I chair the Senate Finance

Committee. I am the Vice-President of the National Conference of State Legislatures (NCSL) and also have the privilege of serving on the National Advisory Council of the National Health Service Corp (NHSC). It is a pleasure to be here today on behalf of NCSL to talk about reauthorizing the National Health Service Corps.

Last year NCSL adopted policy urging you to make the reauthorization of the NHSC a priority. The support for this program is broad, uniting state legislators across urban/rural and racial/ethnic lines. I am particularly pleased to be a part of the effort to move this important reauthorization forward.

The reauthorization of the NHSC is even more important this year. President Bush's proposal to expand the number of Community Health Centers will create an even greater need for clinicians to serve in underserved areas. Just last month a provision that excludes from gross income certain amounts received under the NHSC Scholarship Program was enacted as part of the tax relief package. This benefit is an added incentive to program participation.

The NHSC will be a valuable partner in the effort to expand the number of Community Health Centers, but the value of the NHSC extends far beyond the health profession shortage areas and the uninsured and underinsured individuals and families who benefit from the service requirement. The NHSC facilitates the training of health professionals who, through their service and training, will bring special skills to all the venues they practice in over their lifetime. As our population becomes more diverse, the importance of culturally competent health practitioners will grow. The NHSC is certain to be an important asset.

THE MISSION OF THE NATIONAL HEALTH SERVICES CORPS

NHSC represents a model framework for providing health care services to uninsured and underinsured individuals and families across this nation—a unique collaboration between the federal government, the states, and local communities. Since its development in 1970, the NHSC has played a vital role in expanding access to needed primary health care in communities throughout the United States. Investment in the NHSC pays continuing dividends to the communities in which its clinicians are placed, since two-thirds of these clinicians remain in the community after completion of their service.

Since 1972, NHSC has recruited more than 21,000 health care clinicians to work in areas where, because of financial, geographic, cultural or language barriers, individuals have only limited access to primary medical care. The Corps' focus on minority recruitment has resulted in a significantly greater representation of African-American and Hispanic clinicians in the Corps than exists in the national health care force. These clinicians make an immediate and significant contribution to the overall health of a community.

The program attracts individuals from a variety of primary health care professions, including physicians and physician assistants, nurse practitioners, certified nurse midwives, dentists and dental hygienists, and mental health professionals.

State Loan Repayment Program

In addition to the NHSC Loan Repayment program, 34 states (Alabama, Arizona, California, Colorado, Connecticut, Delaware, Georgia, Illinois, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin) currently receive grants to operate state-based loan repayment programs. These grants match state and local community funds to assist in the repayment of qualified educational loans for primary health care clinicians who, in return for this assistance, agree to practice full time in public or non-profit health facilities in Health Professional Shortage Areas (HPSAs). The specific benefit and eligibility requirements vary by state.

NHSC Loan Repayment Program

The NHSC Loan Repayment Program provides benefits to both the clinician and the health facility. The clinician receives an opportunity to retire debt associated with their health-related training while gaining valuable experience. The health care facilities are able to immediately fill vacancies when loan repayment program participants are available. Everybody benefits.

NHSC Scholarships

The Scholarship Program provides a unique educational opportunity for non-traditional students, especially minority students, low-income students, and students living in rural areas, who might not otherwise be able to pursue a career in primary health care. In 1998, for example, 46.2 percent of medical students awarded scholar-

ships were African-American and Hispanic. Upon graduation, students have an opportunity to make a real difference in the lives of their patients. In 1999, one-third of all patients treated by NHSC personnel had incomes at or below the poverty live. Many others are uninsured and have little access to medical care through traditional providers.

State Initiatives

State efforts to provide primary health care services for their under-served populations are long-standing and encompass a variety of approaches. Not the least important of these approaches are state programs to increase the number of primary health care professionals. The State of Florida, for example, provides 26 scholarship and loan programs for disadvantaged and/or financially needy health professions students. In addition, Florida provides training grants designed specifically to improve access to health care by under-served populations, including training for primary care physicians, dentists, and nursing professionals, as well as training grants to improve public health.

Texas and New Mexico have developed innovative programs using promotoras, or "health promoters," neighborhood women who act as health care advisors for others in the community. These women, in addition to bringing more people into the health care system, help break down language and cultural barriers contributing invaluably to improving the "cultural competence" of all who work beside them.

Many states are exploring, or have already developed, opportunities to use advances in telecommunications to enhance the provision of medical training and health care services, including the provision of mental health, pharmacy, and "telemedicine." These efforts contribute significantly to solutions for solving what has become a crisis in access to primary health care in many communities.

State and local governments continue to explore the full range of approaches to improve access to affordable, quality health care services. These approaches include expansions of coverage through Medicaid and SCHIP, as well as insurance reforms and innovative state-funded programs. Despite the substantial efforts of the National Health Service Corps and the states to develop creative approaches to providing access to primary health care, there remains a significant unmet need for primary health care. The National Health Service Corps, at current funding levels, is able to meet barely twelve percent of this unmet need.

RECOMMENDATIONS

Increase NHSC Funding

Appropriations should be sufficient to allow the NHSC to expand to meet the growing demand for placement by clinicians to provide primary health care services in federally designated underserved areas. The Corps has been successful in recruiting a large number of trained clinicians to its Loan Repayment Program, but funding for the program has not kept pace.

Greater Program Flexibility to Better Meet Community Needs

The goal of NHSC is to be able to educate and recruit primary health care professionals for service in communities experiencing critical shortages of health care providers. Many of these communities consist largely of individuals with specific cultural experiences or ethnic backgrounds. These communities can present special challenges in recruiting and retaining health care providers sensitive to the particular needs of the community. The NHSC recognizes the importance of training culturally-competent and responsive primary health care providers.

Reauthorization of NHSC provides an opportunity to:

- develop additional mechanisms to recruit and retain minority participants;
- augment informal efforts to match communities with specific cultural traditions with health care providers with shared cultural experiences, or who are specifically trained in culturally diverse community-based systems of care;
- increase and formalize efforts to recruit and place health professionals who represent racial and ethnic minorities in communities who request them;
- improve training to encompass cultural competency that considers geographical/regional differences that may affect the health delivery system;
- more directly involve communities in the recruitment, selection and retention of health care professionals through community sponsorships;
- increase the emphasis on public/private partnerships, including faith-based institutions, to enhance community involvement and contractual arrangements with independent health care providers;
- develop programs to assist remote communities, those too small for community health centers, but large enough to need assistance in obtaining primary health care for its citizens; and

- provide technical assistance to states and local communities in implementing NHSC programs and maximizing resources.

Greater Program Flexibility to Better Meet the Needs of Participating Providers

Retaining clinicians in the Corps continues to be a challenge. The reauthorization provides a unique opportunity to explore innovative options to encourage clinicians to stay in the program. Two ideas come to mind.

- *Part-Time Service*—The establishment of demonstration projects and pilot programs allowing participants to work less than full time. The opportunity to serve on a part-time basis could be an important tool in attracting non-traditional providers, including minority health care providers, and prove to be especially attractive in rural areas where traditional health care centers may be not be available.
- *Tax Relief*—Extend to the NHSC Loan Repayment Program, the favorable tax treatment recently afforded to the NHSC Scholarship program in P.L. 107-16. The opportunity to exclude from gross income for federal income tax purposes the amounts of loan payments received from the NHSC would provide an important incentive to clinicians and also provides increased resources to the loan repayment program.

In Conclusion

I look forward to working with this committee and your colleagues in both the House and the Senate to reauthorize the National Health Services Corps this year. I thank you for this opportunity to discuss these important issues with you today and would be happy to answer questions.

Mr. BILIRAKIS. Thank you, Senator.

Mr. Hall.

STATEMENT OF ROBERT HALL

Mr. HALL. Honorable chairman and committee members, and Vice Chairman Brown, thank you for the opportunity to present to you this morning. My name is Bob Hall. I am President of the National Council of Urban Indian Health, and a member of the three affiliated tribes of Fort Berthal, North Dakota—the Arikara, Hidatsa, and Mandan. I am also Executive Director of the South Dakota Urban Indian Health Clinic which operates three clinics in South Dakota. We would like to offer a few remarks on the reauthorization of the legislation.

NCUIH is the only membership organization representing urban Indian Health programs. Our members provide a wide range of health care and referral services in 34 cities, to a population of approximately 332,000 urban Indians. We are often the main source of health care and health information for these urban Indian communities.

According to the 1990 census, 58 percent of American Indians live in urban areas. We expect that the 2000 census is going to indicate that is over 60 percent now live in urban areas. Like their reservation counterparts, urban Indians historically suffer from poor health and substandard health care services.

In 1976, Congress passed the Indian Health Care Improvement Act. The original purpose of this act, as set forth in a contemporaneous report, was to "raise the status of health care for American Indians and Alaska Natives over a 7-year period to a level equal to that enjoyed by American citizens." It has been 25 years since Congress committed to raising the status of Indian health care, and 18 years since the deadline has passed for achieving the goal of equality with other Americans, and yet Indians, whether reservation or urban, continue to occupy the lowest rung on the American health care ladder.

Although the road to equal health care still appears to be a long-time coming, NCUIH believes that Section 330 programs, the Community Access Programs and the National Health Service Corps are all steps in the right direction. NCUIH would like to emphasize, however, the unique characteristics of providing health care to the American Indian population, and the necessity for continuing to support urban Indian health programs that focus nearly exclusively on the urban Indian community.

Many Indians live in urban areas, some permanently, some periodically. It is generally not practical for any one tribal government to set up health service for only its own tribal members in an urban area. In fact, in some urban centers, there are as many as 40 tribal governments nearby, with members of more than 80 different tribes participating in a single urban program.

Urban Indian health programs have arisen specifically to address the uniqueness of Indians in the urban setting, by providing a culturally sensitive, highly supportive environment. Urban Indian health programs have been extraordinarily successful, despite limited resources, at reaching the urban Indian population. Many Indians are not trustful of "mainstream" institutions. Urban Indian programs bridge this distrust and, in so doing, are able to more effectively address the health care issues of the Indian community than non-Indian health care providers. In fact, in the State of South Dakota, the Family Planning Office of the State has made three major attempts in the last 10 years to increase the number of Native American women participating in family planning programs. They have not come close to reaching their goal. This past July 1st, we entered into a contract with them to help achieve that. We already have 25 new enrollees in the family planning program.

In fiscal year 2001, urban Indian health programs received 1.14 percent of the total Indian Health Service budget, although urban Indians constituted at least 50 percent of the total American Indian population and 18 percent of Native Americans served by IHS dollars. NCUIH acknowledges that there are some sound reasons why the lion's share of the IHS budget should go to reservation Indians, however, the health of Indian people in urban areas affects the health of Indian people on reservations and vice-versa. Disease knows no boundaries. NCUIH strongly believes that the health problems associated with the Indian population can only be successfully combatted through a significant funding directed at the urban Indian population as well as at the reservation population.

We hope that as you consider the future of America's health safety net programs you will give consideration to additional support for the urban Indian health program. NCUIH plans to work more closely with the Section 330 Community Health Centers. We are convinced that cooperation will lead to better results for Native peoples, however, we ask for your support in maintaining the independence and uniqueness of urban Indian health programs.

We know from hard-won experience the value of providing a culturally sensitive environment for urban Indians in order to best address the health care needs of this community. America is nowhere near the lofty goal set by the Congress in 1976 of achieving equal health care for American Indians, whether reservation or Indian. NCUIH challenges this committee to think in terms of that goal as

it considers its future of health care programs that operate in underserved communities.

NCUIH thanks this committee for this opportunity to testify concerning urban Indian health. I would be happy to answer any questions the committee may have. Thank you.

[The prepared statement of Robert Hall follows:]

PREPARED STATEMENT OF ROBERT HALL, PRESIDENT, NATIONAL COUNCIL OF URBAN INDIAN HEALTH

"Between the intentions of the lawmakers and the reality of regulatory actions lies the service gap that confronts the urban Indian. The result is untold desperation and waste of human resources."

Final Report of the American Indian Policy Review Commission, Vol. 1, p. 436 (emphasis added).

I. INTRODUCTION

Honorable Chairman and Committee Members, my name is Robert Hall. I am the president of the National Council of Urban Indian Health (NCUIH) and a member of the three affiliated tribes of North Dakota: Arikara, Mandan and Hidatsa. I am also the Executive Director of the South Dakota Urban Indian Health Clinic. On behalf of NCUIH, I would like to express our appreciation for this opportunity to address the Committee on community health centers and urban Indian programs.

NCUIH is the only membership organization representing urban Indian health programs. Our programs provide a wide range of health care and referral services in 34 cities to a population of approximately 332,000 urban Indians. Our programs are often the main source of health care and health information for urban Indian communities. According to the 1990 census, 58% of American Indians live in urban areas, up from 45% in 1970 and 52% in 1980.[1] We expect that the 2000 census will show that over 60% of American Indians now live in urban areas. Like their reservation counterparts, urban Indians historically suffer from poor health and substandard health care services. NCUIH is the successor organization to the American Indian Health Care Association which provided advocacy and educational services on behalf of urban Indian health organizations for nearly 15 years prior to the establishment of NCUIH.

II. SECTION 330, COMMUNITY ACCESS PROGRAMS AND URBAN INDIAN HEALTH PROGRAMS

NCUIH strongly supports the Community Access Program, the National Health Service Corps, and those programs authorized under Section 330 of the Public Health Service Act. NCUIH would like to emphasize, however, the unique characteristics of providing health care to the American Indian population, and the necessity of continuing to support urban Indian health programs that focus nearly exclusively on the urban Indian community.

Many Indians live in urban areas; some permanently, some periodically.[2] It is generally not practical for any one tribal government to set up health service for only its own tribal members in an urban area. In fact, "in some urban centers, there are as many as 40 tribal governments nearby, and representation of tribes on urban Indian programs might include over 80 different tribes."[3] Urban Indian health programs have arisen specifically to address this situation. By providing a culturally-sensitive, highly supportive environment, urban Indian health programs have been extraordinarily successful, despite limited resources, at reaching the urban Indian population. Many Indians are not trustful of "mainstream" institutions. By providing a familiar environment, urban Indian programs bridge this cultural disconnect and, in so doing, more effectively address health care issues of the Indian community than can generally be achieved by non-Indian health care providers.

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[1] According to the 1990 census, 62.3% of American Indians and Alaska Natives reside off reservation. At that time, that figure represented 1.39 million of the 2.24 million American Indians and Alaska Natives. The updated 1990 census identified 58% of American Indians and Alaska Natives as living in urban areas (the other off-reservation Indians live in rural areas). This percentage has probably increased significantly since 1990.

[2] One Federal court has noted that the "patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups." United States v. Raszkiewicz, 169 F.3d 459, 465 (7th Cir. 1999)

[3] U.S. Congress, Office of Technology Assessment, *Indian Health Care,* OTA-H-290 (Washington, DC: U.S. Government Printing Office, April 1986), p. 38.

"Most Indians who migrate to the cities say they would have preferred not to do so at all."

Final Report of the American Indian Policy Review Commission, Vol. 1., p. 436.[4]

The urban Indian is an Indian who has become physically separated from his or her traditional lands and people, generally due to Federal policies. Some of these federal policies were designed to force assimilation and to break-down tribal governments; others may have been intended, at some misguided level, to benefit Indians, but failed miserably. The result of this "course of dealing," however, is the same: a Federal obligation to urban Indians.[5]

A. The Federal Relocation of Indians. The BIA's Relocation program originated in the early 1950s as a response to adverse weather and economic conditions on the Navajo reservation. A limited program was initiated to relieve the distress by finding jobs for Navajos who wanted to work off the reservation. Little or no job opportunities existed on the reservation, so an employment campaign was developed for off-reservation employment. Shortly afterward, the BIA converted its Navajo program into a full-fledged Bureau of Indian Affairs program applicable to many Indian tribes.

The BIA employees who developed the program made many mistakes and miscalculations. Even before the 1950's had ended there was concern that many relocatees were experiencing great difficulty adjusting to life in a large city, or to their jobs. Some felt they were being stranded far away from home. Solving reservation economic problems by relocating Indians off of their tribal lands is roughly the equivalent of the Federal government, during the Depression, sending Americans oversee to find work—something the Federal government would never have done. Many understood the relocation program as just another form of "termination." A Jesuit priest on the Fort Belknap Reservation noted that relocation programs drained the reservation of much of its potential leadership, further weakening tribal governments.

All told, between 1953-1961, over 160,000 Indians were relocated to cities.[6] Where they quickly joined the ranks of the urban poor.[7] Today, the children, grandchildren and great-grandchildren of the 160,000 Indians relocated by the BIA are still in the cities. They maintain their Indian identity even if, in some cases, these "descendants have been unable to re-establish ties (including membership) with their tribes."[8]

B. Failure of Federal Efforts to Economically Develop the Reservations. The second major reason Indians have moved to the city is the near total failure of Federal programs to promote economic development on Indian lands, coupled with the ongoing success of the Federal efforts in the 1800's to undermine the economic way of life of Indian peoples, locking nearly all Indians into hopeless poverty which still plagues most reservations today. The long history of treaty-breaking by the Federal government is an important part of this tale. As a result, out of desperation, a number of Indians have left their homelands to go to the cities in search of work, even without the dubious benefit of the BIA's relocation program. Generally, these Indians were no better equipped to handle life in the city than the BIA

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[5] The unique legal relationship of the United States with Indian tribes and people is defined not only in the Constitution of the United States, treaties, statutes, Executive orders, and court decisions, but also in the "course of dealing" of the United States with Indians. As the Supreme Court noted in a major Indian law case, "[f]rom their very weakness and helplessness, so largely due to the *course of dealing* of the federal government with them, and the treaties in which it has been promised, there arises the duty of protection and with it the power." *United States v. Kagama* (1886) (emphasis added). Congress acknowledged this in its findings to the Native American Housing Assistance and Self-Determination Act: "The Congress through treaties, statutes *and the general course of dealing* with Indian tribes, has assumed a trust responsibility . . . for working with tribes *and their members* to improve their housing conditions and good economic status so that they are able to take greater responsibility for their own economic condition." 25 U.S.C. 4101(4). Notably, NAHASDA also applies to state-recognized tribes. 25 U.S.C. 4103(12)(A).

[6] 1992 Roundtable Conference, Urban Indian Health Programs, Indian Health Service, "Working in Unity Toward our Future." p.2.

[7] "Unfortunately, far too many Indians who move to the cities, because of inadequate academic and vocational skills, merely trade reservation poverty for urban poverty." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652, p. 2747.

[8] *See* Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 22-23.

relocatees and quickly joined the ranks of the urban poor. Congress has noted the correlation between the failure of Federal economic policies and the swelling of the ranks of urban Indians: "It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."[9]

C. Termination of Tribes. In 1953, Congress adopted a policy of terminating the Federal relationship with Indian tribes. Essentially, this was an abrogation of the Federal government's numerous commitments, in treaties, laws, executive orders, and through the "course of dealing" with Tribes, to protect their interests. Many tribes were coerced to accept termination in order to receive money from settlements for claims against the United States for misappropriation of tribal land, water or mineral rights in violation of treaties.[10] The results of termination were devastating: having lost Federal support, and without tribal sovereign authority over an established land basis, and with tribal members no longer eligible for Federal programs and IHS services, the Tribes collapsed. Some members remained in the area of their old reservations; many went to the cities, where they, too, joined the ranks of the urban poor.

D. Indian Patriotism—World War I and World War II. Many Indians served the United States in time of war[11] and, subsequently, were stationed in or near urban centers. At the end of their service to the United States, seeing the poor economic conditions on their reservations (resulting from the Federal war on Indians), many chose not to go back. The fact that they chose to stay in an urban area did not make them any less Indian, nor did it reduce the Federal government's obligation to them.

E. The General Allotment Act. The General Allotment Act ("Dawes Act") had two principal goals: (1) by allocating communal tribal land to individual Indians it would breakdown the authority of the tribal governments while encouraging the assimilation of Indians as farmers into mainstream American culture; and (2) it provided for unalloted land (two-thirds of the Indian land base) to be transferred to non-Indians. CITE. The General Allotment Act succeeded at transferring the majority of Indian land to non-Indians and further disrupting tribal culture. For the purposes of this testimony, we only need to note that some Indians who received allotments became U.S. Citizens and, after losing their lands, moved into nearby cities and towns.

F. Non-Indian Adoption of Indian Children. The common practice of adopting Indian children into non-Indian families has created another group of Indians in urban areas who, because of the racial bias of the courts, have lost their core cultural connection with their tribal people and homelands. Many of the adopted Indians have successfully sought to restore those connections, but because of their upbringing are likely to remain in urban areas.[12]

G. Boarding Schools. The Federal program of taking Indian children and educating them away from their reservations in boarding schools where they were prohibited from speaking their native language and otherwise subject to harsh treatment, created a group of Indians who struggled to fit back into the reservation environment. Eventually, some moved to the cities. The boarding school philosophy of "Kill the Indian, Save the Man" epitomizes the thinking behind this approach and the racist Federal effort to assimilate American Indians which, as a result, led to a number of Indians moving to urban areas.

H. The Fracturing of the Indian Nations. The result of these, and other Federal Indian policies, has been the fracturing of Indian tribes and the creation, in the urban setting, of highly diverse Indian communities with members who fall into one or more of the following categories: Federal relocatees; economic hardship refugees; members of Federally recognized tribes, terminated tribes, state recognized

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[9] Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652,at p. 2754.

[10] Office of Planning, Evaluation and Legislation, Indian Health Service, Impact of the Final Rule Final Report, Contract No. 282-91-0065, "Health Care Services of the Indian Health Service" 42 CFR Part 36, p. 23.

[11] It is in part because of their gallant service in World War I that the U.S. Congress granted U.S. citizenship as a group to American Indians in 1924.

[12] In recognition of the severity of this problem, Congress passed in 1978 the Indian Child Welfare Act to give Tribes and Indian parents a greater say in the adoption process for Indian children. See Indian Child Welfare Act of 1978, 25 U.S.C. Sections 1901-1963.

tribes, and unrecognized Tribes (that is, unrecognized by the Federal government);[13] and adoptees.

IV. THE FEDERAL GOVERNMENT AND THE PROVISION OF HEALTH CARE TO URBAN INDIANS

The Congress has long recognized that its obligation to provide health care for Indians, includes providing health care off the reservation.

> "The responsibility for the provision of health care, arising from treaties and laws that recognize this responsibility as an exchange for the cession of millions of acres of Indian land *does not end at the borders of an Indian reservation.* Rather, government relocation policies which designated certain urban areas as relocation centers for Indians, have in many instances forced Indian people who did not [want] to leave their reservations to relocate in urban areas, and *the responsibility for the provision of health care services follows them there*."

Senate Report 100-508, Indian Health Care Amendments of 1987, Sept. 14, 1988, p. 25 (emphasis added).[14] Congress has "a responsibility to assist" urban Indians in achieving "a life of decency and self-sufficiency" and has acknowledged that "[i]t is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. Unfortunately, the same policies and programs which failed to provide the Indian with an improved lifestyle on the reservation have also failed to provide him with the vital skills necessary to succeed in the cities." House Report No. 94-1026 on Pub. Law 94-437, p. 116 (April 9, 1976).

The Supreme Court has also acknowledged the duty of the Federal government to Indians, no matter where located: "The overriding duty of our Federal Government to deal fairly with Indians *wherever located* has been recognized by this Court on many occasions." *Morton v. Ruiz,* 415 U.S. 199, 94 S.Ct. 1055, 39 L.Ed.2d 270 (1974) (emphasis added), citing *Seminole Nation v. United States,* 316 U.S. 286, 296 (1942); and *Board of County Comm'rs v. Seber,* 318 U.S. 705 (1943). In other areas, such as housing, the Federal courts have found that the trust responsibility operates in urban Indian programs. "Plaintiffs urge that the trust doctrine requires HUD to affirmatively encourage urban Indian housing rather than dismantle it where it exists. The Court generally agrees." *Little Earth of United Tribes, Inc. v. U.S. Department of Justice,* 675 F. Supp. 497, 535 (D. Minn. 1987).[15]

Congress enshrined its commitment to urban Indians in the Indian Health Care Improvement Act where it provided:

> "that it is the policy of this Nation, in fulfillment of its special responsibility and legal obligation to the *American Indian people,* to meet the national goal of providing the highest possible health status to Indians *and urban Indians* and to provide all resources necessary to effect that policy"

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[13] There are still scores of tribes working their way through the byzantine and labyrinthine acknowledgement process, which is widely criticized for its glacial pace and alleged bias against certain Indian groups. Some tribes, like the Lumbee Tribe of North Carolina, have been declared ineligible to go through the administrative process and, therefore, are awaiting Congressional action on their long-prepared, extensively documented petition for federal recognition.

[14] "The American Indian has demonstrated all too clearly, despite his recent movement to urban centers, that he is not content to be absorbed in the mainstream of society and become another urban poverty statistic. He has demonstrated the strength and fiber of strong cultural and social ties by maintaining an Indian identity in many of the Nation's largest metropolitan centers. Yet, at the same time, he aspires to the same goal of all citizens—a life of decency and self-sufficiency. The Committee believes that the Congress has an opportunity and a responsibility to assist him in achieving this goal. It is, in part, because of the failure of former Federal Indian policies and programs on the reservations that thousands of Indians have sought a better way of life in the cities. His difficulty in attaining a sound physical and mental health in the urban environment is a grim reminder of this failure."

"The Committee is committed to rectifying these errors in Federal policy relating to health care through the provisions of title V of H.R. 2525. Building on the experience of previous Congressionally-approved urban Indian health prospects and the new provisions of title V, urban Indians should be able to begin exercising maximum self-determination and local control in establishing their own health programs."

Pub. L. 94-437, House Report No. 94-1026, June 8, 1976, reprinted in 1976 U.S. Cong. & Admin. News (USCAN) 2652 at p. 2754.

[15] Federal responsibility for Indian health care is frequently declared "primary" but it is not exclusive and preemptive of state responsibility. See *McNabb v. Bowen,* 829 F.2d 787, 792 (9th Cir. 1987). Congress enunciated its objective with regard to urban Indians in a 1976 House Report: "To assist urban Indians both to gain access to those community health resources available to them as citizens and to provide primary health care services where those resources are inadequate or inaccessible." H.Rep. No. 9-1026, 94th Cong., 2d Sess. 18, reprinted in 1976 U.S. Cond Cong. & Admin. News (USCAN) 2652, 2657.

25 U.S.C. Section 1602(a)(emphasis added). In so doing, Congress has articulated a policy encompassing a broad spectrum of "American Indian people." Similarly, in the Snyder Act, which for many years was the principal legislation authorizing health care services for American Indians, Congress broadly stated its commitment by providing that funds shall be expended—for the benefit, care and assistance of the Indians *throughout* the United States for the following purposes:. . . For relief of distress and conservation of health." 25 U.S.C. Section 13 (emphasis added).

The courts have also stated that there is a trust responsibility for individual Indians. "The trust relationship extends not only to Indian tribes as governmental units, *but to tribal members living collectively or individually, on or off the reservation." Little Earth of United Tribes, Inc. v. U.S. Department of Justice,* 675 F. Supp. 497, 535 (D. Minn. 1987)(emphasis added). "In light of the broad scope of the trust doctrine, it is not surprising *that it can extend to Indians individually,* as well as collectively, and *off the reservation,* as well as on it." *St. Paul Intertribal Housing Board v. Reynolds,* 564 F. Supp. 1408, 1413 (D. Minn. 1983) (emphasis added).

> "As the history of the trust doctrine shows, the doctrine is not static and sharply delineated, but rather is a flexible doctrine which has changed and adapted to meet the changing needs of the Indian community. This is to be expected in the development of any guardian-ward relationship. *The increasing urbanization of American Indians has created new problems for Indian tribes and tribal members.* One of the most acute is the need for adequate urban housing. Both Congress and Minnesota Legislature have recognized this. The Board's program, as adopted by the Agency, is an Indian created and supported approach to Indian housing problems. *This court must conclude that the [urban Indian housing] program falls within the scope of the trust doctrine. . .*"
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> *Id. At 1414-1415 (emphasis added).*

This Federal government's responsibility to urban Indians is rooted in basic principles of Federal Indian law. The United States has entered into hundreds of treaties with tribes from 1787 to 1871. In almost all of these treaties, the Indians gave up land in exchange for promises. These promises included a guarantee that the United States would create a permanent reservation for Indian tribes and would protect the safety and well-being of tribal members. The Supreme Court has held that such promises created a trust relationship between the United States and Indians resembling that of a ward to a guardian. See *Cherokee Nation v. Georgia,* 30 U.S. 1 (1831). As a result, the Federal government owes a duty of loyalty to Indians. In interpreting treaties and statutes, the U.S. Supreme Court has established "canons of construction" that provide that: (1) ambiguities must be resolved in favor of the Indians; (2) Indian treaties and statutes must be interpreted as the Indians would have understood them; and (3) Indian treaties and statutes must be construed liberally in favor of the Indians. See *Felix S. Cohen's Handbook of Federal Indian Law,* (1982 ed.) p. 221-225. Congress, in applying its plenary (full and complete) power over Indian affairs, consistent with the trust responsibility and as interpreted pursuant to the canons of construction, has enacted legislation addressing the needs of off-reservation Indians.

The Federal courts have also found, that the United States can have an obligation to state-recognized tribes under Federal law. See *Joint Tribal Council of Passamaquoddy v. Morton,* 528 F.2d 370 (1st Cir. 1975). Congress has provided, not only in the IHCIA,[16] but also in NAHASDA, that certain state-recognized tribes or tribal members are eligible for certain Federal programs. 25 U.S.C. Section 4103(12)(A).

V. BARRIERS TO MAINSTREAM HEALTH CARE EXPERIENCED BY URBAN INDIANS[17]

"The lack of employment opportunities leads to a downward spiral that reduces the urban Indian's life to a struggle for subsistence. For example, the private practice system of health care is certainly beyond the financial reach of most newly arrived urban Indian families. They must depend on public services. Yet here, the service gap reveals itself again."

FINAL REPORT OF THE AMERICAN INDIAN POLICY REVIEW COMMISSION, P. 437 (EMPHASIS ADDED).

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[16] As originally conceived, the purpose of the Indian Health Care Improvement Act was to extend IHS services to Indians who live in urban centers. Very quickly, the proposal evolved into a general effort to upgrade the IHS. See, *A Political History of the Indian Health Service,* Bergman, Grossman, Erdrich, Todd and Forquera, The Milbank Quarterly, Vol. 77, No. 4, 1999.

[17] This section is based on the September 30, 1989 report prepared for the American Indian Health Care Association, by Ruth Hograbe, R.D., M.P.H., Program Analyst and Donna Isham, Program Analyst. The framework for the report is the 1988 report *Minority Health in Michigan: Closing the Gap.*

The status of Urban Indian health is as poor as that for reservation Indians.[18] This section describes the many barriers that are still faced by Urban Indians in their efforts to access adequate health care in the urban environment:

Physical/geographic barriers can include (1) telephone availability; less access to transportation; and (3) high mobility. Many Native Americans do not have phones, increasing the difficulty in making appointments. For example, in Arizona, thirty percent of urban Indians have no household access to phone services. Indian people have much less access to private vehicles than the general population. Not having a vehicle creates barriers for people who must make arrangements with others to bring them to appointments. Public transportation (if available) makes for a longer travel time and can be costly. The high mobility of Indian people is another barrier to care. People who move often are not able to follow with the same provider, and this disrupts continuity of care and can lead to a decrease in the quality of care. When a person moves to another area, they must go through the system again to qualify for benefits, locate a provider, and receive care. In addition, movement back and forth between the reservation is common, which can significantly affect the ability of health professionals to provide prompt, quality follow-up care.

Financial/Economic barriers also contribute to the poor quality of urban Indian health care. People who do not have the resources, either through insurance or out-of-pocket, to pay for prevention and early intervention care may delay seeking treatment until a disease or condition has advanced to the stage where treatment is more costly and the probability of survival or correction is lower.

Medicaid is available for urban Indians, but difficult to access. Applying for Medicaid or other medical assistance is a long and detailed process, presenting many barriers to people who don't understand the system or lack the necessary skills to complete the paperwork involved. Furthermore, the required documentation is difficult for many urban Indians to obtain. For example, if one does not have a car, one may not have a drivers license. With high mobility among urban Indians, there is likely to be no documentation with the current address; or if they have just moved to the city from the reservation, there may be no birth certificate or identification. Once an individual is accepted, access to care is not guaranteed. Because of Medicaid reimbursement rates and restrictions, many providers are reluctant to accept Medicaid patients.

Health insurance coverage does not automatically remove financial barriers to care. Many persons, particularly those employed at or near minimum wage, have coverage through plans that do not cover preventive or major medical care. While professional positions generally provide health insurance, service and laborer positions generally do not. Urban Indians hold more of those occupations that do not provide health insurance benefits. Deductibles and co-payments are high enough that many persons who do have health insurance cannot afford to pay them and consequently do not seek care.

No insurance or assistance is another common barrier. Those who have no means to pay for care are often turned away. There is a high rate of urban Indians who are uninsured. For example, in Boston, 87% of the Boston Indian Center's clients have no health insurance, and two out of every three urban Indians in Arizona are uninsured.

Emergency room use is high among the poor, minorities and the uninsured. Unfortunately, emergency room use as a primary medical resource is costly and compromises quality care. Follow-up and preventive services are not possible with emergency room personnel serving as primary care providers. In Arizona, urban Indians use the emergency room 250% more often than the general public.

Cultural/structural barriers also exist for urban Indians receiving health care. The Indian Health Service conducted a survey which concluded that the majority of state, county and city health departments do not have the resources to meet the health care needs of urban Indians. Major stumbling blocks are inadequate funds and lack of staff trained to work with American Indians in a culturally sensitive way. Indians may be reluctant or unable to describe their health needs to strangers outside their own culture. Frequently, mainstream providers misunderstand or misinterpret the reticence and stoicism of some Indians. Other factors include a lack of trained Indian health professionals that get placed in urban Indian health programs and inadequate Indian outreach.

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[18] See *Health Status of Urban American Indians and Alaska Natives,* Grossman et. al, Journal of the American Medical Association, Vol. 271, No. 11, p. 845.

VI. CONCLUSION

Notwithstanding all the difficulties, urban Indian health organizations, working with limited funds, have made a great difference in addressing the health care service gap for urban Indians. There is much more work to be done. NCUIH thanks the Committee for this opportunity to provide testimony on urban Indian health programs.

Mr. BILIRAKIS. Thank you very much, Mr. Hall. We have a vote coming up in a few minutes. I am trying to get this worked out somehow where maybe we can have someone run over, cast their vote, to see if we can keep it rolling. Three votes. That is going to be a problem then. We will have to recess when that takes place. I will start the questioning, if I may.

Ms. Monson, very quickly, you failed to mention—you heard my opening statement and I mentioned the fact that the National Health Service Corps volunteers have the opportunity to buy-out of their contract. Do you have a quick comment on that?

Ms. MONSON. Yes, Mr. Chair. If you look at some of the statistics that I have seen provided by the National Health Service Corps, generally, our participants have met their obligation. I know there has been some discussion about HMOs buying out on behalf of the practitioner, their contracts, but the default rate and the buy-out rate for the programs, I think, if you look at the numbers, are substantially low.

Mr. BILIRAKIS. Should they have the right to do that? After all, there is an obligation there that the taxpayers sent them to school.

Ms. MONSON. I guess, Mr. Chair, when the program was initially created, that someone felt that it was important to give some flexibility to the practitioners for varying reasons. Maybe there should be specific reasons or circumstances within which a clinician could buy-out or pay back their obligation.

I truly believe, however, because of our screening techniques and when you look at those individuals that participate in the program, they come into the program not just because of the free education in terms of the Corps Scholarship Program or the Loan Repayment Program, but they come because they are committed to service in underserved areas. And I would imagine that situation exists more than 98 or 99 percent of the time.

Mr. BILIRAKIS. You may be right about those percentages, but I have personally experienced this situation in one of the clinics in my district, and it hurt the clinic badly.

Ms. MONSON. Let me suggest one thing that we have talked about as a Council——

Mr. BILIRAKIS. Well, let me just continue on. Please consider that. You are right, maybe it is probably 98, 99 percent, I don't know what that percentage is, but I don't know that it should be just 98, 99, I think it ought to be 100.

Ms. MONSON. It should be 100 percent.

Mr. BILIRAKIS. Yes. So will you offer the committee suggestions, any ideas that you may have in writing to us on changing that, if you believe in it. If you don't, that is a different story.

Ms. MONSON. We certainly have, and we as a Council have discussed options to address that situation. We would be happy to provide that information.

Mr. BILIRAKIS. Great. Thanks, Senator.

Dr. Duke, do your statistics include the private clinic, the non-330 clinics that exist around the country?

Ms. DUKE. The statistics I used in my testimony this morning reflect the health centers that are under the 330 progam, so that when we talk about the statistics on care for the minorities and so forth, those are our health care clinics.

Mr. BILIRAKIS. So, in other words, we do not know—there is no way to know how many clinics are out there who are doing essentially the same type of work, that are not part of the 330 program?

Ms. DUKE. We are aware of the—there are a lot of providers that are called "look-a-likes." We also have rural health clinics and small rural hospitals that provide services as well, so that there is a network of provision of care that goes beyond the health centers about which my statistics spoke this morning.

Mr. BILIRAKIS. So the answer then is we don't know how many there might be. For instance, there is a Clearwater Free Clinic in Clearwater, Florida. Are you aware of that?

Ms. DUKE. Sir, I don't know the specifics of that particular area, but I can get back to you with a fuller answer that could lay that out, and I would be delighted to do that.

Mr. BILIRAKIS. Would you do that, I think that would be very helpful.

Continuing in that vein, Ms. Benjamin and Mr. Brewton particularly, Ms. Benjamin, your clinic, its history was in being about 10 years before you decided to apply for 330 funding.

Ms. BENJAMIN. Yes.

Mr. BILIRAKIS. All right. And, Mr. Brewton, you indicated that your clinic was operating a few years before apply for 330 funding. Have you seen substantial changes in terms of the intent of the clinic? In other words, a lot of these clinics that I have referred to, Dr. Duke, they tell me they just don't want any government involvement. They don't want the government telling them what to do, in spite of the fact that they need the funding and could probably serve a lot more people, and be able to hire some providers, whereas now they are all volunteers, literally all volunteers, including the people at the front desk. Can you both put in the record what changes you have seen? Have you seen any reason why you should not have gone into Federal funding?

Ms. BENJAMIN. There is absolutely no reason why we shouldn't have gone—no, it has supplemented our services tremendously to have——

Mr. BILIRAKIS. You haven't seen any change in terms of the intent in terms of how you wanted to serve the public?

Ms. BENJAMIN. Not a negative intent, but a more positive intent.

Mr. BILIRAKIS. Mr. Brewton, of course, did speak very powerfully about the positive——

Mr. BREWTON. Same answer. It has actually, I think, helped us create stronger commitments, and I would also argue that when it comes to cumbersome regulations and paperwork, compared to managed care, you guys are amateurs.

Mr. BILIRAKIS. We have heard that 2 or 3 times over the years.

Ms. BENJAMIN. I would also like to say that initially when the clinic started with volunteer staff, it really started to address the huge needs of people with children with ear infections and things

like that, that acutely needed attention. And after Section 330 funding, the whole impetus of the center really changed toward preventive health care, and it has continued on in those directions, and that is how we eliminate disparities.

Mr. BILIRAKIS. That is what we want, of course.

Mr. BREWTON. 330 required us to form a Quality Assurance Committee, and as a result of that committee we are taking the individual observations of practitioners and building them into systems that more effectively deal with all our patients, not just hit-or-miss.

Mr. BILIRAKIS. I would like to spend a lot more time on that particular subject, but my time is long over. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Mr. Singer, than you especially for your testimony, it was just terrific, one of the best I have heard here in a long time, so thank you for that, and thank you for being with us, to all of you.

I don't normally do commercials like this, but I listened to your comments about the homeless, about housing issues, about health care issues, and I recently read a book by Barbara Aronwright called "Nickel and Dime," which I suggest to everyone in this room. I have not financial interest in this, but suggest everyone in this room that they read. And she talks about the working poor. She actually took jobs several places around the country, very low-paying, $6-an-hour, $7-an-hour jobs, talked about the working poor, and especially talked about housing and how to rent an apartment, you need the security deposit. You often need the first and last months' rent, so people making $6 and $7 an hour in maid service, or Wal-Mart or in a nursing home, end up staying at terrible hotels, paying $25 a night, end up—don't have refrigerators and stoves, so it cost more to be poor, in many ways, because they can't cook a batch of lentil soup and freeze and eat it all week, they have to go to convenience stores and grocery stores, and then their food spoils if they try to keep it, and whatever. And she talked about one young man who got hurt at work, he had an infection in his foot. He couldn't afford the antibiotic. He didn't show up at work for 3 days, and he was fired as a result. And when you talk about—you know, we talk about health disparities in this country, we are 5 percent of the world's population. We consume 45 percent of health care expenditures in this world, yet we have so many people that don't get the kind of care they should. We have the best health care system in the world for the affluent, but for others we often don't, unless they are lucky enough to get service from Mr. Brewton or many of the rest of you, but we are not reaching them. We should be ashamed of ourselves, and I don't see the commitment in this Congress and this administration to move forward with the way—or, for that matter, most of the last several years, to move forward the way that we should, to not just eliminate the health care disparities, but the income disparities that so much go with it. And that being said, thank you again for joining us.

Dr. Duke, I would like to ask you a question. I also want to apologize, I have a markup in another committee, and if I am moving in and out, it is not for a lack of interest, it is because I have to go vote occasionally.

Dr. Duke, I was pleased to hear you affirm your agency's commitment to the mission. I have heard, however, that you intend to

abandon the 100 percent/zero campaign. I note on your Website the campaign name is now called "Improving expanding access." So, a copy of a memo from Laura Perki, with the Bureau of Primary Health Care, dated July 6, "Effective immediately, all publications with the phrase '100 percent access, zero health disparities,' should be changed to 'improving and expanding access to health care for all Americans nationwide'".

In Ohio, the infant mortality rate for African-Americans is 2.5 times that of whites, 10 percent higher than the national average for African-American infants, and 3.5 times higher than the Healthy People 2010 goal. Ohio, as many other States, to be sure, has a long way to go to reach the Healthy People 2010 goal, and I am concerned about your mission statement change. What is HRSA's mission? Why the reason, are we just lowering our expectations, is that what we as a government, we as a society, this administration wants to do? Explain it to me, if you would.

Ms. DUKE. This morning, I represent President Bush and Secretary Thompson, who are both committed to enhancing access to quality care for all Americans and eliminating disparities in health care, and I spoke in a cleared statement that said that HRSA's mission is to work toward 100 percent access to health care and zero disparities, and we are committed to working toward that.

As a manager, one of my concerns is to set realistic goals in the short-term that we can bite off, chew, and accomplish. And so as we go through each year, our goal will be to accomplish meaningful progress toward—as the statement says, working toward 100 percent access and zero disparities. Our goal this year is to expand our health care network across the country, and we have committed to a budget in 2002 that would allow us to increase and expand access points by 200 and to increase care for 1 million people in the year 2002. That is a down payment on a 5-year program of 5 years of expansion of our health centers that will increase those health centers by 1200 sites and eventually double the number of patients served. We are committed to working toward quality health care for all Americans.

Mr. BROWN. Mr. Chairman, if I could do one more question. I hear you, but I also see sort of the direction that we may be moving, and I look at the Title 7 program, and my understanding is the administration is eliminating all funding for Title 7. That includes student loans, it includes health professions, training for diversity, it includes health professions, public health workforce, also opposing funding for the Community Access Programs. Were these decisions—was this downgrading of goals—lowering of expectations might be a less judgmental way to say it—lowering of expectations and eliminating the funding for these programs, are these decisions made by the President, or by Secretary Thompson, or by Dr. Duke, or who makes these decisions—or OMB—to eliminate the funding for those to send a message that we are not going to fund student loans, help professions train for diversity, and these very important Community Access Programs? Tell me that.

Mr. BILIRAKIS. A very brief response, please, Dr. Duke, much briefer than the question.

Mr. BROWN. Much briefer than the question. That is why the chairman and I get along so well.

Ms. DUKE. The administration's position is that they have made decisions oriented toward the best use of available funding. In the area of the Community Access Program, hard choices were made to target funding for direct care of patients and, thus, the goal of increasing by 1 million people in 2002 the number of patients who could be served from our Community Health Center network. And that is as a commitment, a 5-year commitment to expanding that available health care so that eventually over 20 million people will have direct health care as a result of the decisions reached.

The decision of the administration was that to build another funding stream in the CAP program was not the most efficient or effective way to bring about the improvement of health care for the most vulnerable in our Nation.

Mr. BILIRAKIS. I hate to—we have this vote coming up and it would be great if we could finish up with this panel and let them go home, except for possibly Dr. Duke or one of your representatives. We always like to have someone from the administration sort of staying for the next panel so they can sort of take notes and learn from it. If you would do that, I would appreciate it.

Ms. DUKE. I would be delighted.

Mr. BILIRAKIS. Mr. Pitts, to inquire.

Mr. PITTS. Thank you, Mr. Chairman. I apologize, I had to step out. I am in a markup in another committee, and I missed Mr. Hall's testimony, but I would like to start with you, Mr. Hall.

Is it a requirement that someone who seeks care at an IHS facility be an enrolled member of a federally recognized tribe and, if so, don't the facilities, in effect, discriminate on the basis of race?

Mr. HALL. It is true for the IHS facilities, that you have to be an enrolled member of federally recognized tribes, but the urban Indian clinics, because most of us are federally qualified health clinics, that requirement is not on us. So we see non-Indians in the urban clinic.

Mr. PITTS. How many facilities in the Indian Health Services receive Section 330 funding?

Mr. HALL. I don't think any of them receive them direct. Two or three of our urban clinics do have a relationship with some of the 330 clinics in their area.

Mr. PITTS. Do you know, in your home State of South Dakota, how many clinics receive Section 330 funding?

Mr. HALL. I believe there are 21 clinics in South Dakota, under seven organizations that receive 330 money. Sioux Falls has one 330 clinic, Rapid City has two, one a medical service, one a homeless, and then the remainder of the 330 clinics are all very rural clinics.

Mr. PITTS. Thank you. Mr. Brewton, some of the members and staff are concerned that someone with a religious faith or faith-based community service would somehow turn away certain patients or refuse medical care. Can you expand a little bit on your written testimony so that once and for all you can disabuse any of us from any misapprehension we may have on that?

Mr. BREWTON. The best way to do that would be to invite you to the office and to meet the practitioners who carry out the mission, but again it is our faith perspective that says all people are created in God's image, and so there are no barriers to walking

through the door. There is no question about what kind of insurance you have when you first come in, nor is there a question about are you religious or do you want to pray? Our concern is what is your need and how can we meet that need? So it is hard to prove a negative, but discrimination and exclusion are just the polar opposites of what we are about.

Mr. PITTS. Thank you. Ms. Benjamin, thank you for coming today, and I wanted to ask you to expand a little bit on something you mentioned in the testimony, and that is your efforts to offer service at satellite health services, and how you work with other institutions. I think you mentioned a Baptist Church. Can you expand on your cooperation with other organizations in providing service?

Ms. BENJAMIN. Sure. In particular, we work very closely with faith-based organizations in the community. Several of them are represented on our board. Some of the larger organizations are represented on our board. And some of the discussions at the board level about accessing services have reflected the fact that there are a lot of people in our community who are walking around with diabetes and hypertension that is undiagnosed, and the only way that we can probably reach these people is to go to where they are, and they won't be coming to the health center because they don't even know that they need the services. So we have talked to several of the churches about opening clinics at their churches, and one in particular will be opening next year. So we are really excited about being able to reach those people who are walking around undiagnosed right now.

Mr. PITTS. In reauthorizing Community Health Centers, are there steps that Congress can take to improve coordination between community health centers and hospitals or between community health centers themselves?

Ms. BENJAMIN. The Community Access Program will be extremely instrumental for us. We have already, in Lancaster, developed an infrastructure—actually all the health care providers, including the hospitals and private physicians, the Health Care for the Homeless group, we are all working together and we have built an infrastructure, but we don't have funding to staff permanently, on a daily basis, anyone to really carry out the work, although that is very important. And, really, I guess, National Health Service Corps will certainly help as well.

Mr. PITTS. Thank you very much. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Ms. Capps. Let us stay within the 5 minutes, please, so we can finish up. I wasn't talking to you, specifically.

Ms. CAPPS. That is my goal because I have two different kinds of questions, so I am going to try to be brief on this. One of the witnesses—the trouble with these panels is that they are related, though different topics, so if I could segue into the next panel, one of the witnesses, Dr. Russell Roberts, argues—he is from Washington University. He argues that government funding designed to encourage the development of health care professionals is where I am headed, and his written statement indicates that the market would provide the optimum mix of doctors, nurses and other health care professionals.

First, I would like to hear what the administration thinks of the notion of removing all government funding of health professional education and training, and then perhaps one panel, maybe Dr. Wiltz, just to keep it to the time, and then I want to switch to flexibility in funding of NAHC, too.

Ms. DUKE. Thank you very much. The market may produce an aggregate number over the long-run, but then Cain said in the long-run, you are all dead, so I will pick up that theme. Our concern as a Nation has to be the way we produce a full-fledged range of health care providers, including the other health professions that don't always get mentioned, so we need to look at all the other health care providers in addition to the shortage areas. And shortage areas are also interesting phenomenon as well because you may have in aggregate enough providers, but they may not be geographically distributed, which is one very big problem.

And a second problem is the relative diversity of the provider population to the population at-large. And so while the concept of the market over the long-run might be sufficient, I think when you step back and look at the diversity of the professions themselves, the diversity of the population and the whole issue of geographic distribution, I think there is a role for government. Further, there is a role for government in actually understanding what those availabilities are, and that is one of the roles of government, to provide the data by which we know what professions are in emerging shortages so that we have an opportunity as a society to make decisions about how we will handle those.

Ms. CAPPS. Thank you.

Mr. WILTZ. I can tell you who I am and where I am because of the National Health Service Corps. I was just sharing with Dr. Duke, I found a periodical produced in 1972 which was a period when I was a medical student. It was because of National Health Service Corps and Scholarship Program that I was able to attend Tulane University and serve the people that I have served for the last 19 years.

If market forces would have solved this problem—we use the Star Trek motto about the "boldly go where no one else will go"—if that were true, then profit-margin driven practices would have gone to these areas. I do believe that government plays a role, a vital role. We believe in population parity, that our workforce should reflect what we are represented in this Nation, and we have always been committed to that.

I would just like to summarize and say that we have built them, they have come, and once they come there, we need the people to serve them, and we need the people that can serve them that are culturally competent and qualified to do so.

In addressing ours, I think the mantra to our State Legislature, local problems deserve local solutions by local people, and we need to be at the foremost front of that argument by serving the communities that we represent, putting the patient first, using a team approach not with a Doc at the top, faced in the center, building the circle with all the providers and all the wraparound services.

Ms. CAPPS. Thank you. And you provide a segue for my next question which is more specific. Perhaps, Dr. Duke, to the goal of flexibility, more flexibility in the NHSC, and this is about nurse-

practitioners. That is what you were talking about perhaps in a way, Dr. Wiltz.

Before 1990, nurse-practitioners, midwives, physician's assistants, got very little support from the NHSC. If there is flexibility in the set-asides, if there is a waiver again, what do anticipate will happen? What can we do to prevent shortfalls in this area?

Ms. DUKE. The area of shortfalls in nursing, pharmacists and other health providers is a concern. We are trying to document what those shortfalls are. And the Secretary has been very concerned about, for example, the emerging nursing shortage that we face as a Nation. He visited us for a week and spent time with us looking at various problems that we are grappling with every day. And he met for over an hour with a group of representatives of the nursing profession, for example, to look at what are the problems in the different phases of nursing education, nursing recruitment, nursing training, and he is very committed.

We have in our 2002 budget money for increasing the diversity of the nursing workforce and increasing the basic nurse training program. And also, as a result of the Secretary's visit with us, in which we spent a good deal of time on the subject of the emerging nursing shortage, the Secretary went back to the Department and basically used his transfer authority to give us an additional $5 million this year, in 2001, for us to make available nurse education loan repayment opportunities which we will use this year to put 400 new nurses in underserved areas, as a result of what he heard about this shortage. So, it is an area we are very concerned about.

Mr. BILIRAKIS. Thank you.

Ms. CAPPS. If I could get one more yes or no. The flexibility won't eliminate the standards for nurse-practitioners?

Ms. DUKE. I am not sure I understood that question, I am sorry.

Ms. CAPPS. The set-aside.

Ms. DUKE. We have not put in any discussion of set-asides, so I really am not in a position to talk about that, but I will try to get back to you on that.

Mr. BILIRAKIS. We will have written questions, as we customarily do, after the hearing, and we would expect that you would be willing, within just a matter of a few days, respond to those. Possibly, Ms. Capps, you can broach it that way. Mr. Bryant. And we do have three votes, so right after Mr. Bryant we are gone for a little while.

Mr. BRYANT. Thank you, Mr. Chairman. Mr. Brewton, I don't know what your political background is, but I want you running my next campaign. Put that on your calendar.

Mr. BILIRAKIS. He is a Pittsburgher, I can probably guess his affiliation. I am sorry, go ahead.

Mr. BRYANT. One of my housemates is also from Pittsburgh and has another persuasion, too.

Ms. Benjamin, you mentioned in either your oral testimony or your written testimony that a majority of the Hispanic residents that you serve have little or no English proficiency, and I don't think there is any question that that would impact the patient-doctor communication relationship.

My question is, what challenges, very quickly, do you face in hiring bilingual, bicultural health professionals, and do you have any recommendations for us?

Ms. BENJAMIN. Our largest challenge is the financial challenge, and additional funding will remedy that. It is very difficult to hire bilingual and bicultural providers, especially physicians and physician assistants and nurse-practitioners, actually all of them, with the amount of funding that we can afford. And actually bilingual and bicultural African-American providers generally cost us about 30 percent more than non-African-American. So that is just the economy that we have right now, and the high demand that there is for bilingual and bicultural people.

Mr. BRYANT. Thank you. Dr. Duke, several questions and, as the chairman has indicated, you can respond in writing. I will read through a couple of these very quickly. Is there evidence that employers stop insuring low-wage workers once a community health center moves into the area? And if that is the case, what would be your suggestion on how we could address that issue here in Congress? You could give us your answer in writing on that one, as well as the extent to which you are able to determine, what amount of fraud is taking place in that area of community health center programs?

And let me move on to a couple of quick comments and, finally, a question or two for you to answer because I am concerned about some of the numbers. Generally, as I understand, two programs involved here in the NHSC regarding payment for education, one is a scholarship which obviously you don't pay back, the other is I guess a loan type which is repaid, and statistically I am seeing numbers that show actually more people who are recipients of the loan repayment stay in the area longer after their commitment expires than people who are on scholarships, and it is something like 79.2 percent versus 61.9 percent overstay, which is what we want them to do, their commitment. Do you have any quick answer on that because I have another one I want to ask you, so I don't want to take the rest of my time on that one, but do you have a quick response to that?

Ms. DUKE. The concern we have is to increase our retention rate for both our scholars and our loan-repayers, and I will get you more information on the difference in that ratio in writing.

Mr. BRYANT. Would you also address whether—I assume it is, but I want to confirm it—the financial status for these applicants for the loan program or the scholarship, if their financial status plays a role in what they get, and I am assuming it does, but I need to know that also.

One final question—again, on the same program, NHSC program—our numbers show that 22 percent of the shortage areas, when they receive doctors in this situation, actually are enough to lift them over into another category of provider-to-population ratio, while 65 percent of the areas, the shortage areas, never receive any providers at all and, to me, that shows that there is not maybe enough thought being given to where people are assigned—when you are sending them to areas that are already marginal almost to the point where they don't need these types of doctors, they are not underseved areas once they get there—to the point where you have

got 65 percent of the shortage areas not receiving any doctors, clearly underserved areas that need those. Again, if you could address that with any comments you have now, or—since the caution light is on and the red light is about to come on, it would be better if you address that in your written, late-filed testimony.

Ms. DUKE. I will provide the information in writing, and this is an area of our concern and we are looking at the shortage designation definition.

Mr. BRYANT. Thank you.

Mr. BILIRAKIS. I thank the gentleman, and I thank the panel. You really have been a terrific panel, and we have learned an awful lot from you. We have a second panel coming up.

I am going to go ahead and recess until 12:45, give the second panel a chance to grab a bite to eat, and the rest of us, too. Thank you again so very much.

[Recess]

Mr. BILIRAKIS. The hearing will come to order. The second panel consists of Janet Heinrich, of the General Accounting Office; Linda O'Leary, I have already mentioned her, she is with the Federation of American Health Systems, the Chief Nursing Officer at the Regional Medical Center in Bayonet Point, Florida, part of my congressional district—welcome, Linda. Mr. Brown would like to introduce the next witness.

Mr. BROWN. I am glad to say Diana Baker works as a urology/gynecology nurse at the Cleveland Clinics, from Newton Falls, Ohio, which, if you check the address, is the only community in the whole country that has a single digit zip code, 44444. So, if you learn nothing else today, you know that. Welcome, Ms. Baker.

Mr. BILIRAKIS. I probably should not have done that.

Mr. BROWN. A little local color, Mr. Chairman.

Mr. BILIRAKIS. Dr. Cory Roberts, Director of Anatomic Pathology, St. Paul Medical Center, Department of Pathology, Dallas, Texas; Ms. Adele Pietrantoni, a Trustee at the American Pharmaceutical Association, and Dr. Russell Roberts, a John M. Olin Senior Fellow at the Weidenbaum Center on the Economy, Government and Public Policy, Washington University, St. Louis, Missouri. Welcome, Doctor.

As per usual, your written statement is a part of the record, and we would appreciate it if you would supplement, or whatever the case might be. I will set the clock at 5 minutes. I would appreciate if you would try to keep your remarks within that 5 minutes but, obviously, if you go over slightly, I won't cut you off, but we do want to try to finish up. We have the energy bill on the floor, and there is generally an awful lot of amendments to that, so we might have some interruptions, but hopefully not. Ms. Heinrich, please proceed.

STATEMENTS OF JANET HEINRICH, DIRECTOR, HEALTH CARE-PUBLIC HEALTH ISSUES, U.S. GENERAL ACCOUNTING OFFICE; LINDA O'LEARY, FEDERATION OF AMERICAN HEALTH SYSTEMS, CHIEF NURSING OFFICER, REGIONAL MEDICAL CENTER, BAYONET POINT, HUDSON, FLORIDA; DIANA BAKER; CORY ROBERTS, DIRECTOR OF ANATOMIC PATHOLOGY, ST. PAUL MEDICAL CENTER, DEPARTMENT OF PATHOLOGY, DALLAS, TEXAS; ADELE PIETRANTONI, TRUSTEE, AMERICAN PHARMACEUTICAL ASSOCIATION; AND RUSSELL ROBERTS, JOHN M. OLIN SENIOR FELLOW, WEIDENBAUM CENTER ON THE ECONOMY, GOVERNMENT AND PUBLIC POLICY, WASHINGTON UNIVERSITY, ST. LOUIS, MISSOURI

Mr. Chairman and members of the subcommittee, we are pleased to be here today as you discuss issues related to the health care workforce and the reauthorization of the Federal safety net programs to improve access to care. My testimony will discuss growing concern about the adequacy of the health care workforce and emerging shortages especially among nurses and nurse aides, and focus on some lessons learned from the experience of the National Health Service Corps in addressing the maldistribution of available health care professionals.

While current data on workforce supply and demand are not adequate to determine the magnitude of any imbalance, available evidence suggests emerging shortages for the largest categories of health care workers, nurses and nurse aides. Both the demand for and supply of health workers are influenced by many factors. For example, with respect to registered nurses, demand not only depends on the care needs of the population, but also on how providers—hospitals, nursing homes, and others—decide to use nurses in delivering care.

In the past, providers have changed staffing patterns, employing fewer or more nurses relative to other workers at various times. Recent studies suggest that hospitals and other providers in many areas of the country are experiencing greater difficulty in recruiting health care workers. For example, a survey in Maryland reported a statewide average RN vacancy rate for hospitals of 14.7 percent in 2000, up from 3.3 percent in 1997. The same survey reported a 12.4 percent vacancy rate for pharmacists, and a 13.6 percent vacancy rate for laboratory technicians. Many States are also reporting that nurse aide recruitment and retention is a major workforce issue, especially in nursing homes and home health care.

Job dissatisfaction has been identified as a major factor contributing to the current problems in recruiting and retaining nurses and nurse aides. Among nurses, inadequate staff, heavy workloads, and the increased use of overtime are frequently cited as key concerns. Low wages, few benefits, and difficult working conditions are linked to high turnover among nurse aides.

The demand in health care is expected to grow dramatically in the coming years as the population continues to age. The Bureau of Labor Statistics predicts that demand for laboratory technologists, RNs, and nurse aides will grow by approximately 20 percent by 2008, compared to 14 percent in all other occupations. The growth for personal and home health aides is predicted to grow by

more than 58 percent. During this time, the number of women between 25 and 54 years of age, who have traditionally formed the core of the nursing workforce, is expected to remain relatively unchanged.

In addition to concerns about the overall supply of health care professionals, the distribution of available workers across geographic areas is an ongoing public health concern. The National Health Service Corps is one safety net program that directly places primary care professionals in these medically needy areas. Some have proposed expanding the Corps or developing similar programs to address additional health care disciplines, such as Registered Nurses, pharmacists, and medical laboratory personnel.

While the Corps has had some success in addressing the geographic distribution of physicians and other providers, our past work has identified several lessons to consider in developing national workforce policies. These include how the Corps identifies and measures the need for health care workers, how the Corps placements are coordinated with other programs and with its own placements, and what incentives, scholarships or loan repayments, are a better approach to attract practitioners to targeted geographic areas.

We have identified numerous problems with the way that HHS decides whether an area is a health professional shortage area, a HPSA, a designation required for the Corps placement. The current approach does not count some practitioners already working in the area, such as nurse practitioners or current Corps members. The Corps also needs to coordinate its placement with other efforts to attract physicians to needy areas, such as the J-1 visa waiver program for non-U.S. citizens who have just completed their graduate medical education in the United States.

Another issue is how to most effectively attract health care professionals to the Corps. We found that the loan repayment program costs less per year of service, that loan repayment recipients are more likely to complete their service obligations, and that loan repayment recipients are more likely to continue practicing in the underserved community after completing their obligation. Therefore, it may be effective to target a larger portion of funds to loan repayment instead of scholarships.

In conclusion, providers' current difficulty recruiting and retaining health care workers could worsen if demand increases in the future. More detailed data are needed to delineate the extent and nature of workforce shortages to assist in targeting corrective efforts. Programs like the National Health Service Corps can play a role in improving the distribution of health care workers, however, it is important that we evaluate the performance of this program adequately so that it is structured to maximize impact.

Mr. Chairman, this concludes my prepared statement, and I will, of course, be happy to answer questions.

[The prepared statement of Janet Heinrich follows:]

PREPARED STATEMENT OF JANET HEINRICH, DIRECTOR, HEALTH CARE-PUBLIC HEALTH ISSUES, GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today as you discuss issues related to the health care workforce and the reauthorization of federal safety net programs to improve access to care for medically under-

served populations. As you know, there is growing concern that many Americans will go without needed health care services because worker shortages or geographic maldistribution of certain types of health care professionals may develop.

Changes in the U.S. health care system over the past two decades have affected the environment in which a variety of health professionals and paraprofessionals provide care. For example, while hospitals traditionally were the primary providers of acute care, advances in technology, along with cost controls, have shifted much care from traditional inpatient settings to ambulatory or community-based settings, nursing facilities, and home health care settings. In addition, the transfer of less acute patients to nursing homes and community-based-care settings created a broader range of health care employment opportunities. These changes have led to concerns regarding the adequacy of the health care workforce. And while the adequacy of the health care workforce is an important issue nationwide, the distribution of available health professionals is a particularly acute issue in certain locations. These medically underserved areas, ranging from isolated rural areas to inner cities, have problems attracting and retaining health care professionals.

My testimony will discuss (1) growing concerns about the adequacy of the health care workforce and emerging shortages in some fields, particularly among nurses and nurse aides, and (2) the lessons learned from the experience of one federal program—the Department of Health and Human Services' (HHS) National Health Service Corps (NHSC)—in addressing the maldistribution of health care professionals. My comments are based on our previous work in these areas and limited follow-up work we conducted to update the findings and recommendations contained in earlier reports.[1]

In brief, while current data on supply and demand for many categories of health workers are limited, available evidence suggests emerging shortages in some fields, for example, among nurses and nurse aides. Many providers are reporting rising vacancy and turnover rates for these workers, contributing to growing concerns about recruiting and retaining qualified health professionals. These concerns are likely to increase in the future as demographic pressures associated with an aging population are expected to both increase demand for health services and limit the pool of available workers such as nurses and nurse aides.

Regarding the experience of the NHSC, while the program has placed thousands of health professionals in needy communities since its establishment in 1970, our work has identified several areas for HHS and the Congress to consider in discussing NHSC reauthorization. For example, we found problems with HHS' system for identifying and measuring the need for NHSC providers. In addition, the NHSC placement process is not well coordinated with other efforts to place physicians in underserved areas and does not assist as many needy areas as possible. Finally, regarding the financing mechanism used to attract health care professionals to the NHSC, our analysis found that educational loan repayment is preferable over scholarships in most situations.

HEALTH WORKFORCE ISSUES ARE A GROWING CONCERN

Recruitment and retention of adequate numbers of qualified workers are major concerns for many health care providers today. While current data on supply and demand for many categories of health workers are limited, available evidence suggests emerging shortages in some fields, for example, among nurses and nurse aides. Many providers are reporting rising vacancy and turnover rates for these worker categories. In addition, difficult working conditions and dissatisfaction with wages have contributed to rising levels of dissatisfaction among many nurses and nurse aides. These concerns are likely to increase in the future as demographic pressures associated with an aging population are expected to both increase demand for health services and limit the pool of available workers such as nurses and nurse aides. As the baby boom generation ages, the population of persons age 65 and older is expected to double between 2000 and 2030, while the number of women age 25 to 54, who have traditionally formed the core of the nursing workforce, will remain virtually unchanged. As a result, the nation may face a caregiver shortage of different dimensions from those of the past.

[1] See appendix I for a list of these reports.

Evidence Suggests Emerging Health Worker Shortages in Some Fields

Nurses and nurse aides are by far the two largest categories of health care workers, followed by physicians and pharmacists.[2] While current workforce data are not adequate to determine the magnitude of any imbalance between supply and demand with any degree of precision, evidence suggests emerging shortages of nurses and nurse aides to fill vacant positions in hospitals, nursing homes, and other health care settings. Hospitals and other providers throughout the country have reported increasing difficulty in recruiting health care workers, with national vacancy rates in hospitals as high as 21 percent for pharmacists in 2001. Rising turnover rates in some fields such as nursing and pharmacy are another challenge facing providers and are suggestive of growing dissatisfaction with wages, working environments, or both.

Data on Health Workforce Supply and Demand Are Limited

There is no consensus on the optimal number and ratio of health professionals necessary to meet the population's health care needs. Both demand and supply of health workers are influenced by many factors. For example, with respect to registered nurses (RN), demand not only depends on the care needs of the population, but also on how providers—hospitals, nursing homes, clinics, and others—decide to use nurses in delivering care. Providers have changed staffing patterns in the past, employing fewer or more nurses relative to other workers at various times. National data are not adequate to describe the nature and extent of nurse workforce shortages nor are data sufficiently sensitive or current to allow a comparison of the adequacy of nurse workforce size across states, specialties, or provider types.

With respect to pharmacists, there are also limited data available for assessing the adequacy of supply, a situation that has led to contradictory claims of a surplus of pharmacists a few years ago and a shortage at the present time. While several factors point to growing demand for pharmacy services such as the increasing number of prescriptions being filled, a greater number of pharmacy sites, and longer hours of operation, these pressures may be moderated by expanding access to alternative dispensing models such as Internet and mail-order delivery services.

Providers Report High Vacancy Rates for Many Health Care Workers

Recent studies suggest that hospitals and other health care providers in many areas of the country are experiencing increasing difficulty recruiting health care workers.[3] A recent 2001 national survey by the American Hospital Association reported an 11 percent vacancy rate for RNs, 18 percent for radiology technicians, and 21 percent for pharmacists.[4] Half of all hospitals reported more difficulty in recruiting pharmacists than in the previous year, and three-quarters reported greater difficulty in recruiting RNs. Urban hospitals reported slightly more difficulty in recruiting RNs than rural hospitals. However, rural hospitals reported higher vacancy rates for several other types of employees. Rural hospitals reported a 29 percent vacancy rate for pharmacists and 21 percent for radiology technologists compared to 15 percent and 16 percent respectively among urban hospitals.

A recent survey in Maryland conducted by the Association of Maryland Hospitals and Health Systems reported a statewide average RN vacancy rate for hospitals of 14.7 percent in 2000, up from 3.3 percent in 1997.[5] The Association reported that the last time vacancy rates were at this level was during the late 1980s, during the last reported nurse shortage. Also in 2000, Maryland hospitals reported a 12.4 percent vacancy rate for pharmacists, a 13.6 percent rate for laboratory technicians, and 21.0 percent for nuclear medicine technologists. These same hospitals reported taking 60 days to fill a vacant RN position in 2000 and 54 days to fill a pharmacy vacancy in 1999.

Several recent analyses illustrate concerns over the supply of nurse aides. In a 2000 study of the nurse aide workforce in Pennsylvania, staff shortages were reported by three-fourths of nursing homes and more than half of all home health care

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[2] In 1999, there were approximately 2.2 million nurse aides, 2.2 million registered nurses, 688,000 licensed practical or vocational nurses, 313,000 physicians, and 226,000 pharmacists employed in the United States according to the Bureau of Labor Statistics.

[3] Caution must be used when comparing vacancy rates from different studies. While nurse vacancy rates are typically the number of budgeted full-time RN positions that are unfilled divided by the total number of budgeted full-time RN positions, not all studies identify the method used to calculate rates.

[4] American Hospital Association, *The Hospital Workforce Shortage: Immediate and Future,* (Washington, D.C.: AHA, 2001).

[5] Association of Maryland Hospitals & Health Systems, *MHA Hospital Personnel Survey 2000,* (Elkridge, MD: MHA, 2001).

agencies.[6] Over half (53 percent) of private nursing homes and 46 percent of certified home health care agencies reported staff vacancy rates higher than 10 percent. Nineteen percent of nursing homes and 25 percent of home health care agencies reported vacancy rates exceeding 20 percent. A recent survey of providers in Vermont found high vacancy rates for nurse aides, particularly in hospitals and nursing homes; as of June 2000, the vacancy rate for nurse aides in nursing homes was 16 percent, in hospitals 15 percent, and in home health care 8 percent. In a recent survey of states, officials from 42 of the 48 states responding reported that nurse aide recruitment and retention were currently major workforce issues in their states.[7] More than two-thirds of these states (30 of 42) reported that they were actively engaged in efforts to address these issues.

High Rates of Turnover Experienced in Some Fields

Rising turnover rates in many fields are another challenge facing providers and suggest growing dissatisfaction with wages, working environments, or both. According to a recent national hospital survey, rising rates of turnover have been experienced, particularly in nursing and pharmacy departments.[8] Turnover among nursing staff rose from 11.7 percent in 1998 to 26.2 percent in 2000. Among pharmacy staff, turnover rose from 14.6 percent to 21.3 percent over the same period. Nursing home and home health care industry surveys indicate that nurse turnover is an issue for them as well.[9] In 1997, an American Health Care Association (AHCA) survey of 13 nursing home chains identified a 51-percent turnover rate for RNs and licensed practical nurses (LPN).[10] A 2000 national survey of home health care agencies reported a 21-percent turnover rate for RNs.[11]

Many providers also are reporting problems with retention of nurse aide staff. Annual turnover rates among aides working in nursing homes are reported to be from about 40 percent to more than 100 percent. In 1998, a survey sponsored by AHCA of 12 nursing home chains found 94-percent turnover among nurse aides.[12] A more recent national study of home health care agencies identified a 28 percent turnover rate among aides in 2000, up from 19 percent in 1994.[13]

High rates of turnover may lead to higher provider costs and quality of care problems. Direct provider costs of turnover include recruitment, selection, and training of new staff, overtime, and use of temporary agency staff to fill gaps. Indirect costs associated with turnover include an initial reduction in the efficiency of new staff and a decrease in nurse aide morale and group productivity. In nursing homes, for example, high turnover can disrupt the continuity of patient care—that is, aides may lack experience and knowledge of individual residents or clients. When turnover leads to staff shortages, nursing home residents may suffer harm because there remain fewer staff to care for the same number of residents.

Working Conditions and Wages Contribute to Job Dissatisfaction Among Nurses and Nurse Aides

Job dissatisfaction has been identified as a major factor contributing to the current problems providers report in recruiting and retaining nurses and nurse aides. Among nurses, inadequate staffing, heavy workloads, and the increased use of overtime are frequently cited as key areas of job dissatisfaction. A recent Federation of Nurses and Health Professionals (FNHP) survey found that half of the currently employed RNs surveyed had considered leaving the patient-care field for reasons other than retirement over the past 2 years; of those who considered leaving, 18 percent wanted higher wages, but 56 percent wanted a less stressful and less physically

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[6] Joel Leon, Jonas Marainen, and John Marcotte, *Pennsylvania's Frontline Workers in Long Term Care* (Jenkintown, Pa.: Polisher Research Institute at the Philadelphia Geriatric Center, 2001).

[7] North Carolina Division of Facility Services, *Comparing State Efforts to Address the Recruitment and Retention of Nurse Aide and Other Paraprofessional Aide Workers* (Raleigh, N.C.: Sept. 1999).

[8] Hospital & Healthcare Compensation Service, *Hospital Salary and Benefits Report 2000-2001* (Oakland, N.J.: Hospital & Healthcare Compensation Service, 2000).

[9] As with vacancy rates, caution should be used when comparing turnover rates from different studies. Nurse turnover rates are typically the number of nurses that have left a facility divided by the total number of nurse positions. However, there is no standard method for calculating turnover, and methods used in different studies may vary.

[10] American Health Care Association, *Facts and Trends 1999, The Nursing Facility Sourcebook* (Washington, D.C.: AHCA, 1999).

[11] Hospital & Healthcare Compensation Service, *Homecare Salary and Benefits Report 2000-2001* (Oakland, N.J.: Hospital & Healthcare Compensation Service, 2000).

[12] American Health Care Association, *Staffing of Nursing Services in Long Term Care: Present Issues and Prospects for the Future* (Washington, D.C.: AHCA, 2001).

[13] *Homecare Salary and Benefits Report, 2000-2001,* 2000.

demanding job.[14] Other surveys indicate that while increased wages might encourage nurses to stay at their jobs, money is not generally cited as the primary reason for job dissatisfaction. The FNHP survey found that 55 percent of currently employed RNs were either just somewhat or not satisfied with their facility's staffing levels, while 43 percent indicated that increased staffing would do the most to improve their jobs.

For nurse aides, low wages, few benefits, and difficult working conditions are linked to high turnover. Our analysis of national wage and employment data from the Bureau of Labor Statistics (BLS) indicates that, on average, nurse aides receive lower wages and have fewer benefits than workers generally. In 1999, the national average hourly wage for aides working in nursing homes was $8.29, compared to $9.22 for service workers and $15.29 for all workers. For aides working in home health care agencies, the average hourly wage was $8.67, and for aides working in hospitals, $8.94. Aides working in nursing homes and home health care are more than twice as likely as other workers to be receiving food stamps and Medicaid benefits, and they are much more likely to lack health insurance. One-fourth of aides in nursing homes and one-third of aides in home health care are uninsured compared to 16 percent of all workers. In addition, other studies have found that the physical demands of nurse aide work and other aspects of the environment contribute to retention problems. Nurse aide jobs are physically demanding, often requiring moving patients in and out of bed, long hours of standing and walking, and dealing with patients or residents who may be disoriented or uncooperative.

Demand for Most Health Workers Will Continue to Grow While Demographic Pressures May Limit Supply

Concern about emerging shortages may increase as the demand for health care services is expected to grow dramatically with the continued aging of the population. In most job categories, health care employment is expected to grow much faster than overall employment, which BLS projects will increase by 14.4 percent from 1998 to 2008. As shown in Table 1, total employment for personal and home care aides is expected to grow by 58 percent, with 567,000 new workers needed to meet the increased demand and replace those who leave the field. Employment of physical therapists is expected to grow by 34 percent, and employment of RNs is projected to grow by almost 22 percent, with 794,000 new RNs expected to be needed by 2008.

Table 1: Projected Employment Growth for Selected Occupations, 1998-2008

Occupation	1998 employment (in thousands)	Percent growth in employment 1998-2008	Total projected job openings, 1998-2008 (in thousands) [1]
All occupations	140,514	14.4	54,622
Physicians	577	21.2	212
Dentists	160	3.1	38
Registered nurses	2,079	21.7	794
Pharmacists	185	7.3	64
Physical therapists	120	34.0	59
Clinical laboratory technicians and technologists	313	17.0	93
Radiology technicians and technologists	162	20.1	55
Nurse aides, orderlies and attendants	1,367	23.8	515
Personal and home health aides	746	58.1	567

[1] Total projected openings are due to both growth in demand and net replacements.
Source: U.S. Department of Labor, Bureau of Labor Statistics, ''Occupational Employment Projections to 2008,'' Monthly Labor Review, November 1999.

Demographic pressures will continue to exert significant pressure on both the supply and demand for nurses and nurse aides. A more serious shortage of nurses and nurse aides is expected in the future, as pressures are exerted on both supply and demand. The future demand for these workers is expected to increase dramatically when the baby boomers reach their 60s, 70s, and beyond. Between 2000 and 2030, the population age 65 years and older will double from 2000 to 2030. During that same period the number of women age 25 and 54, who have traditionally formed the core of the nurse and nurse aide workforce, is expected to remain relatively un-

[14] Federation of Nurses and Health Professionals, *The Nurse Shortage: Perspectives from Current Direct Care Nurses and Former Direct Care Nurses* (opinion research study conducted by Peter D. Hart Research Associates)(Washington, D.C.: 2001).

changed. Unless more young people choose to go into the nursing profession, the workforce will continue to age. By 2010, approximately 40 percent of nurses will likely be older than 50 years. By 2020, the total number of full time equivalent RNs is projected to have fallen 20 percent below HRSA's projections of the number of RNs that will be required to meet demand at that time.[15]

NHSC ILLUSTRATES CHALLENGES IN ADDRESSING SHORTAGES OF HEALTH PROFESSIONALS IN CERTAIN LOCATIONS

In addition to concerns about the overall supply of health care professionals, the distribution of available providers is an ongoing public health concern. Many Americans live in areas—including isolated rural areas or inner city neighborhoods—that lack a sufficient number of health care providers. The National Health Service Corps (NHSC) is one safety-net program that directly places primary care physicians and other health professionals in these medically needy areas. The NHSC offers scholarships and educational loan repayments for health care professionals who, in turn, agree to serve in communities that have a shortage of them. Since its establishment in 1970, the NHSC has placed thousands of physicians, nurse practitioners, dentists, and other health care providers in communities that report chronic shortages of health professionals. At the end of fiscal year 2000, the NHSC had 2,376 providers serving in shortage areas. Since the NHSC was last reauthorized in 1990, funding for its scholarship and loan repayment programs has increased nearly 8-fold, from about $11 million in 1990 to around $84 million in 2001.[16]

Some have proposed expanding the NHSC or developing similar programs to include additional health care disciplines, such as nurses, pharmacists, and medical laboratory personnel. In considering such possibilities, HHS and the Congress may want to consider our work that has identified several ways in which the NHSC could be improved. These include how the NHSC identifies the need for providers and how it measures that need, how the NHSC placements are coordinated with other programs and with its own placements, and which financing mechanism—scholarships or loan repayments—is a better approach to attract providers to those areas.

Current System for Identifying Need is Inadequate

Over the past 6 years, we have identified numerous problems with the way HHS decides whether an area is a health professional shortage area (HPSA), a designation required for a NHSC placement.[17] In addition to identifying problems with the timeliness and quality of the data used, we found that HHS' current approach does not count some providers already working in the shortage area.[18] For example, it does not count nonphysicians providing primary care, such as nurse practitioners, and it does not count NHSC providers already practicing there. As a result, the current HPSA system tends to overstate the need for more providers, leading us to question the system's ability to assist HHS in identifying the universe of need and in prioritizing areas.

Recognizing the flaws in the current system, HHS has been working on ways to improve the designation of HPSAs, but the problems have not yet been resolved. After studying the changes needed to improve the HPSA system for nearly a decade, HHS published a proposed rule in the *Federal Register* in September 1998. The proposed rule generated a large volume of comments and a high level of concern about its potential impact. In June 1999, HHS announced that it would conduct further analyses before proceeding. HHS continues to work on a revised shortage area designation methodology; however, as of July 2001, it did not have a firm date for publishing the proposed new regulations.

The controversy surrounding proposed modifications to the HPSA designation system may be due, in large part, to its use by other programs. Originally, it was only used to identify an area as one that could request a provider from the NHSC. Today many federal and state programs—including efforts unaffiliated with HHS—use the

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[15] "Peter I. Beurhaus, Douglas O. Staiger, and David I. Auerbach, "Implications of an Aging Registered Nurse Workforce," *JAMA, Vol. 283, No. 22 (June 14, 2000).*

[16] In addition to funding for scholarship and loan repayment awards, the NHSC receives funding for support of its providers and operations. In fiscal year 2001, this field budget was about $41 million.

[17] Only areas designated as a HPSA may apply for NHSC providers. Currently, HHS considers a HPSA generally to be a location or area with less than one primary care physician for every 3,500 persons. As of June 30, 2001, HHS identified 2,968 primary care HPSAs. To eliminate these HPSA designations, HHS identified a need of over 6,000 full-time physicians. HHS has different criteria for dental and mental health HPSAs.

[18] See *Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved* (GAO/HEHS-95-200, Sept. 8, 1995).

HPSA designation in considering program eligibility. These areas want to get and retain the HPSA designation in order to be eligible for such other programs as the Rural Health Clinic program or a 10 percent bonus on Medicare payments for physicians and other providers.

Better Coordination of Placements With Waivers for J-1 Visa Physicians Is Needed

The NHSC needs to coordinate its placements with other efforts to attract physicians to needy areas. There are not enough providers to fill all of the vacancies approved for NHSC providers. As a result, underserved communities are frequently turning to another method of obtaining physicians—attracting non-U.S. citizens who have just completed their graduate medical education in the United States.[19] These physicians generally enter the United States under an exchange visitor program, and their visas, called J-1 visas, require them to leave the country when their medical training is done. However, the requirement to leave can be waived if a federal agency or state requests it. A waiver is usually accompanied by a requirement that the physician practice for a specified period in an underserved area. In fiscal year 1999, nearly 40 states requested such waivers. They are joined by several federal agencies—particularly the Department of Agriculture, which wants physicians to practice in rural areas, and the Appalachian Regional Commission, which wants to fill physician needs in Appalachia.

Waiver placements have become so numerous that they have outnumbered the placements of NHSC physicians. In September 1999, over 2,000 physicians had waivers and were practicing in or contracted to practice in underserved areas, compared with 1,356 NHSC physicians. In 1999, the number of waiver physicians was large enough to satisfy over one-fourth of the physicians needed to eliminate HPSA designations nationwide. Our follow-up work in 2001 with the federal agencies requesting the waivers and 10 states indicates that these waivers are still frequently used to attract physicians to underserved areas.

Although coordinating NHSC placements and waiver placements has the obvious advantage of addressing the needs of as many underserved locations as possible, this coordination has not occurred. In fact, this sizeable domestic placement effort—using waiver physicians to address medical underservice—is rudderless. Even among those states and agencies using the waiver approach, no federal agency has responsibility for ensuring that placement efforts are coordinated.[20] The Administration has recently stated that HHS will enhance coordination between the NHSC and the use of waiver physicians; however HHS does not have a system to take waiver physician placements into account in determining where to put NHSC physicians. While some informal coordination may occur, it remains a fragmented effort with no overall program accountability. As a result, some areas have ended up with more than enough physicians to remove their shortage designations, while needs in other areas have gone unfilled.

As the Congress considers reauthorizing the NHSC, it also has the opportunity to address these issues. We believe that the prospects for coordination would be enhanced through congressional direction in two areas. The first is whether waivers should be included as part of an overall federal strategy for addressing underservice. This should include determining the size of the waiver program and establishing how it should be coordinated with other federal programs. The second—applicable if the Congress decides that waivers should be a part of the federal strategy—is designating leadership responsibility for managing the use of waivers as a distinct program.

Better Placement Process is Needed

While congressional action could foster a coordinated federal strategy for placement of J-1 waiver physicians, our work has also shown that congressional action could help ensure that NHSC providers assist as many needy areas as possible. We previously reported that at least 22 percent of shortage areas receiving NHSC providers in 1993 received more NHSC providers than needed to lift their provider-to-population ratio to the point at which their HPSA designation could be removed, while 65 percent of shortage areas with NHSC-approved vacancies did not receive any providers at all.[21] Of these latter locations, 143 had unsuccessfully requested

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[19] See *Foreign Physicians: Exchange Visitor Program Becoming Major Route to Practicing in U.S. Underserved Areas* (GAO/HEHS-97-26, Dec. 30, 1996).

[20] Historically, HHS has not supported the waiver approach as a sound way to address underservice needs in the United States. While HHS is considering the issue, the agency still takes the position that physicians should return home after completing their medical training to make their knowledge and skills available to their home countries.

[21] To calculate oversupply, we counted physicians as one full-time provider and nonphysicians (nurse practitioners, nurse midwives, or physician assistants) as one-half a full-time provider.

a NHSC provider for 3 years or more.[22] In response to our recommendations, the NHSC has subsequently made improvements in its procedures and has substantially cut the number of HPSAs not receiving providers. However, these procedures still allow some HPSAs to receive more than enough providers to remove their shortage designation while others go without.

NHSC officials have said that in making placements, they need to weigh not only assisting as many shortage areas as possible, but also factors—such as referral networks, office space, and salary and benefit packages—that can affect the chance that a provider might stay beyond the period of obligated service. Since the practice sites on the NHSC vacancy list had to meet NHSC requirements, including requirements for referral networks and salary and benefits packages, such factors should not be an issue for those practice locations. And while we agree that retention is a laudable goal, the impact of the NHSC's current practice is unknown, since the NHSC does not routinely track how long NHSC providers are retained at their sites after completing their service obligations. The Congress may want to consider clarifying the extent to which the program should try to meet the minimum needs of as many shortage areas as possible, and the extent to which additional placements should be allowed in an effort to encourage provider retention.

Loan Repayment Is a Better Approach than Scholarships

Another issue that is fundamental to attracting health care professionals to the NHSC is the allocation of funds between scholarships and educational loan repayments. Under the NHSC scholarship program, students are recruited before or during their health professions training—generally several years before they begin their service obligation. By contrast, under the NHSC loan repayment program, providers are recruited at the time or after they complete their training. The scholarship program provides a set amount of aid per year while in school, while the loan repayment program repays a set amount of student debt for each year of service provided. Under the Public Health Service Act, at least 40 percent of the available funding must be for scholarships.

We looked at which financing mechanism works better and found that, for several reasons, the loan repayment program is the better approach in most situations.[23]

- *The loan repayment program costs less.* On average, each year of service by a physician under the scholarship program costs the federal government over $43,000 compared with less than $25,000 under loan repayment.[24] A major reason for the difference is the time value of money. Because 7 or more years can elapse between the time that a physician receives a scholarship and the time that the physician begins to practice in an underserved area, the federal government is making an investment for a commitment for service in the future. In the loan repayment program, however, the federal government does not pay until after the service has begun. The difference in average cost per year of service could increase in the future as a result of a recent change in tax law.[25]
- *Loan repayment recipients are more likely to complete their service obligations.* This is not surprising when one considers that scholarship recipients enter into their contracts up to 7 or more years before beginning their service obligation, during which time their professional interests and personal circumstances may change. Twelve percent of scholarship recipients between 1980 and 1999

If only physician placements are counted, 6 percent of these shortage areas would still be identified as oversupplied. We consider these estimates of oversupply to be conservative because our analysis does not include NHSC providers placed in prior years who were still in service during vacancy year 1993.

[22] See *National Health Service Corps: Opportunities to Stretch Scarce Dollars and Improve Provider Placement* (GAO/HEHS-96-28, Nov. 24, 1995).

[23] See GAO/HEHS-96-28.

[24] Amounts are in 1999 dollars. This cost analysis is based on new scholarship and new federal loan repayment awards made in fiscal year 1999.

[25] In analyzing the net cost differences, we took into account the federal income tax liability associated with scholarship and loan repayment awards. In essence, loan repayment awards are increased to provide for the resulting increased federal tax liability; scholarship awards are not. However, as a result of the Economic Growth and Tax Relief Reconciliation Act of 2001 (P.L. 107-16, Sec. 413), beginning January 1, 2002, scholarship payments of tuition, fees, and other reasonable educational costs will not be subject to federal income tax. As a result, the net cost to the federal government of a year of service under the NHSC scholarship program will increase.

breached their contract to serve,[26] compared to about 3 percent of loan repayment recipients since that program began.

- *Loan repayment recipients are more likely to continue practicing in the underserved community after completing their obligation.* How long providers remain at their sites after fulfilling their obligation is not fully clear, because the NHSC does not have a long-term tracking system in place. However, we analyzed data for calendar years 1991 through 1993 and found that 48 percent of loan repayment recipients were still at the same site 1 year after fulfilling their obligation, compared to 27 percent for scholarship recipients. Again, this is not surprising. Because loan repayment recipients do not commit to service until after they have completed training, they are more likely to know what they want to do and where they want to live or practice at the time they make the commitment.

These reasons support applying a higher percentage of NHSC funding to loan repayment. The Congress may want to consider eliminating the current requirement that scholarships receive at least 40 percent of the funding. Besides being generally more cost-effective, the loan repayment program allows the NHSC to respond more quickly to changing needs. If demand suddenly increases for a certain type of health professional, the NHSC can recruit graduates right away through loan repayments. By contrast, giving a scholarship means waiting for years for the person to graduate.

This is not to say that scholarships should be eliminated. One reason to keep them is that they can potentially do a better job of putting people in sites with the greatest need because scholarship recipients have less latitude in where they can fulfill their service obligation. However, our work indicates that this advantage has not been realized in practice. For NHSC providers beginning practice in 1993-1994, we found no significant difference between scholarship and loan payment recipients in the priority that NHSC assigned to their service locations. This suggests that the scholarship program should be tightened so that it focuses on those areas with critical needs that cannot be met through loan repayment. In this regard, the Congress may want to consider reducing the number of sites that scholarship recipients can choose from, so that the focus of scholarships is clearly on the neediest sites.[27] While placing greater restrictions on service locations could potentially reduce interest in the scholarship program, the program currently has more than six applicants for every scholarship—suggesting that the interest level is high enough to allow for some tightening in the program's conditions. If that approach should fail, additional incentives to get providers to the neediest areas might need to be explored.

CONCLUDING OBSERVATIONS

Providers' current difficulty recruiting and retaining health care professionals such as nurses and others could worsen as demand for these workers increases in the future. Current high levels of job dissatisfaction among nurses and nurse aides may also play a crucial role in determining the extent of current and future nursing shortages. Efforts undertaken to improve the workplace environment may both reduce the likelihood of nurses and nurse aides leaving the field and encourage more young people to enter the nursing profession. Nonetheless, demographic forces will continue to widen the gap between the number of people needing care and the nursing staff available to provide care. As a result, the nation will face a caregiver shortage of different dimensions from shortages of the past. More detailed data are needed, however, to delineate the extent and nature of nurse and nurse aide shortages to assist in planning and targeting corrective efforts.

Regarding the NHSC, addressing needed program improvements would be beneficial. In particular, better coordination of NHSC placements with waivers for J-1 visa physicians could help more needy areas. In addition, addressing shortfalls in HHS systems for identifying underservice is long overdue. We believe HHS needs to gather more consistent and reliable information on the changing needs for services in underserved communities. Until then, determining whether federal resources are appropriately targeted to communities of greatest need and measuring their impact of these reasons will remain problematic.

Mr. Chairman, this concludes my prepared statement. I would be pleased to respond to any questions you or members of the Subcommittee may have.

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[26] This includes scholarship recipients who defaulted and paid the default penalty, those who defaulted and subsequently completed or are serving their obligation, and those who defaulted and have not begun service or payback.

[27] The law provides for three vacancies for each scholar in a given discipline and specialty, up to a maximum of 500 vacancies. For example, if there are 10 pediatricians available for service, the NHSC would provide a list of 30 eligible vacancies for that group if there were 500 or fewer vacancies in total.

GAO CONTACTS AND ACKNOWLEDGEMENTS

For further information regarding this testimony, please call Janet Heinrich, Director, Health Care—Public Health Issues, at (202) 512-7119 or Frank Pasquier, Assistant Director, Health Care, at (206) 287-4861. Other individuals who made key contributions to this testimony include Eric Anderson and Kim Yamane.

Appendix I—Related GAO Reports

Nursing Workforce: Emerging Nurse Shortages Due to Multiple Factors (GAO-01-944, July 10, 2001)

Nursing Workforce: Multiple Factors Create Nurse Recruitment and Retention Problems (GAO-01-912T, June 27, 2001)

Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides Is a Growing Concern (GAO-01-750T, May 17, 2001)

Health Care Access: Programs for Underserved Populations Could Be Improved (GAO/T-HEHS-00-81, Mar. 23, 2000)

Community Health Centers: Adapting to Changing Health Care Environment Key to Continued Success (GAO/HEHS-00-39, Mar. 10, 2000)

Physician Shortage Areas: Medicare Incentive Payments Not an Effective Approach to Improve Access (GAO/HEHS-99-36, Feb. 26, 1999)

Health Care Access: Opportunities to Target Programs and Improve Accountability (GAO/T-HEHS-97-204, Sept. 11, 1997)

Foreign Physicians: Exchange Visitor Program Becoming Major Route to Practicing in U.S. Underserved Areas (GAO/HEHS-97-26, Dec. 30, 1996)

National Health Service Corps: Opportunities to Stretch Scarce Dollars and Improve Provider Placement (GAO/HEHS-96-28, Nov. 24, 1995)

Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995)

Mr. BILIRAKIS. Thank you very much, ma'am.

Ms. O'Leary.

STATEMENT OF LINDA O'LEARY

Ms. O'LEARY. Good afternoon, Mr. Chairman and members of the committee. My name is Linda O'Leary. I am the Vice President and Chief Nursing Officer at Regional Medical Center Bayonet Point in Hudson, Florida. I am pleased to testify this afternoon on behalf of the Federation of American Hospitals on the critical issue of the growing health care workforce shortage.

At Bayonet Point, we have a 290-bed acute care facility that is part of a larger hospital system, HCA, which owns 200 hospitals across the country. As the CNO, I would like to convey my personal experiences in maintaining an adequate workforce as well as a snapshot of the shortage as a whole.

The shortages of nurses and other health care providers within health care facilities is a growing problem across this country. In some areas, the crisis is imminent; in others, it has arrived.

According to a recent survey by the American Hospital Association, hospitals have up to 168,000 open positions, 126,000 of which are Registered Nurses. The decline in new nurse graduates in combination with the rapid aging of the existing pool of nurses and the aging population paints a picture of health care delivery in significant stress.

The Florida Hospital Association recently released their nurse staffing report which details the extent of this shortage. The study revealed an overall vacancy rate for RNs of 15.6 percent, and because of the shortage the survey found that the use of temporary agencies was reported by 83 percent of the hospitals surveyed.

At HCA, our company's contract labor costs have increased an average of 28 percent over the last year, and the labor wage costs have gone up 7 percent in the first 6 months of this year alone. At my hospital, our current vacancy rate for RNs is 25 percent, which translates to about 80 open RN positions.

We also have a number of recruitment efforts underway. At our hospital, we offer tuition reimbursement for all employees who pursue health care careers. Bayonet Point and six other hospitals in our area have a new partnership with Pasco-Hernando Community College. We have agreed to fund additional teachers in the nursing program, and each hospital has the opportunity to provide scholarship money for up to 25 students at a time. In return, each student agrees to work for us 2 to 3 years for return of the scholarship money. We currently have 16 students joining us in August.

Another outreach effort we have underway is educating career counselors at the junior high school and high school levels, about the field of nursing and the opportunities within the health care field.

Beyond recruitment, we must also focus on nurse retention. Bayonet Point has instituted bonus programs, and we often modify work schedules to meet personal needs. One very important component of retaining nurses is asking their opinion. We seek out ways to involve nurses in care and treatment options and we look for devices to reduce the difficult physical demands of the profession.

Our nurses are dealing with an increased acuity level and limited resources. My job as a CNO is to listen to my staff, to understand their concerns, and to work in partnership with them to resolve issues as quickly as possible. I also use every opportunity to promote nursing as a very rewarding career.

Beyond what we are doing locally, we are also focusing efforts on recruitment of nurses abroad. Dr. Frank M. Houser, M.D., HCA's Senior Vice President and Medical Director, just returned from travel to India in an effort to recruit nurses, however, the opportunities for international recruitment are extremely limited. Regular green card applicant nurses are still coming into the United States, but at an extremely low rate. The H-1C and H-1B programs are extremely limited.

We would like to work with Congress and the Department of Labor to review and expand existing visa programs so the United States is not at a competitive disadvantage in terms of recruiting nurses from abroad.

The problems of the shortage are so vast and so complex that we are looking to Congress and the administration for help. Broadly, the Federation supports legislation that seeks to improve recruitment, nursing faculty, and community outreach, the development of the Nurse Service Corps, eliminate regulatory burden, and reviewing and expanding the immigration laws. Specifically, members of this committee have introduced legislation that would attempt to increase the number of workers entering the nursing workforce and provide opportunities and incentives to alleviate the shortage. The Nurse Reinvestment Act introduced by Representatives Capps and Kelly, has many valuable ideas, however, as written, all Federation members would be excluded, many of which serve rural and underserved populations. We are working to amend the legislation to ensure that their creative solutions to the workforce crisis are helpful to all hospitals.

The promising piece of legislation introduced by members of this committee in the Nurse of Tomorrow Act, introduced by Represent-

atives Engel and Bono, the Federation applauds the bill's sponsors for including all facilities in this legislation.

In conclusion, I have been a nurse for over 30 years and, frankly, I cannot imagine doing anything else. Federation members and all health care facilities are facing a workforce crisis. Our hospitals are on the front lines of delivering patient care, but our most precious resource, our workers, are in very short supply. We look forward to working with you to attempt to solve this complex and growing problem. I would be happy to answer any questions at this time.

[The prepared statement of Linda O'Leary follows:]

PREPARED STATEMENT OF LINDA O'LEARY, VICE PRESIDENT AND CHIEF NURSING OFFICER, REGIONAL MEDICAL CENTER BAYONET POINT

Good morning Mr. Chairman and members of the Committee, my name is Linda O'Leary and I am Vice President and Chief Nursing Officer at Regional Medical Center Bayonet Point in Hudson Florida. I am pleased to testify this morning on behalf of the Federation of American Hospitals (FAH) on the critical issue of the growing healthcare workforce shortage.

The Federation is the national trade association representing some 1,700 privately-owned and managed community hospitals and health systems providing health care across the acute and post-acute spectrum. Our member hospitals provide care for patients in both urban and rural America.

At Bayonet Point, we have a 290 bed acute care facility that is part of a larger hospital system owned by HCA, Inc. We have adopted a range of activities in my hospital, and at the corporate level to recruit and retain an adequate supply of RNs and other caregivers. As the Chief Nursing Officer I would like to convey my personal experiences in maintaining an adequate workforce at Bayonet Point, as well as a snapshot of the shortage as a whole.

THE PROBLEM

The issue of shortages of nurses and other health care providers, and retention of them within healthcare facilities, is a growing problem across the country. In some areas, the crisis is imminent, in others—it has arrived. Nurses in specialty areas such as operating room nurses, emergency room nurses and intensive care nurses are in particularly short supply.

The Federation recently convened an ad hoc task force to assist in gathering information regarding the depth and breath of the shortage and to solicit its members' ideas and action plans to address the shortage. The task force has members from all Federation companies and is composed of professionals representing a range of specialties within their corporations.

Essentially our member hospitals have told us that:

- The shortage is hitting hospitals across the country geographically, in rural, urban and suburban settings;
- Worker shortages are primarily in the field of nursing (especially those in the critical care areas), but also extend to radiological technologists, operating room technologists, and pharmacists, to name a few;
- Hospitals have undertaken a wide range of creative recruitment and retention activities including mentoring programs, modified work schedules, community outreach partnerships with vocational schools, and nursing programs, providing sites for clinical rotations, scholarship programs, subsidizing nursing faculty salaries and web advertising;
- The issue of state licensure complicates the ability of workers to practice across state lines;
- Hospitals are employing a range of approaches to counteract the shortage, including signing and retention bonuses.

A new report by Fitch, IBCA, Duff & Phelps entitled "Health Care Staffing Shortage" states "The fundamental problem is the decreasing relative supply of nurses in this country. As of March 2001, there were 2.7 million licensed registered nurses (RNs) in the U.S., with 2.2 million employed in nursing. "Currently, 80%-85% of hospitals have reported a nurse shortage, and nationwide there is a 10%-12% vacancy rate of nurses in health care facilities."

The American Hospital Association recently completed a survey of more than 700 hospitals across the country. Their study revealed that "Hospitals have up to 168,000 open positions—126,000 of those are for registered nurses." Also, according

to the survey, 21% of hospitals have openings for pharmacists, while 18% had unfilled positions for radiological technologists.

The problem will grow worse as the nursing population ages. According to the Health Resources & Services Administration (HRSA) and the American Organization of Nurse Executives (AONE), the average age of nurses in the year 2000 was 48. (See attached chart #1). According to the American Nurses Association (ANA) "Approximately 50% of nurses are entering their 50s, and many will leave the workforce within the next 10 years. As of 1996, only 9% of nurses were under the age of 30." The shortage has attracted attention across the country as hospitals report growing vacancies and their advocates in Washington call for action. The Federation is certainly not alone in calling for federal assistance in this area, the American Hospital Association, the American Nurses Association and the American Medical Association have all issued statements recognizing the extent of the problem.

The job of an RN has changed over the last twenty years. With a higher proportion of patients with complex care needs and greater acuity, there has been an increased demand for nurses with specialized training. Many nurses entered the profession because of its nurturing nature, patient stays are now shorter and more care is delivered on an outpatient basis, thus limiting the nurse-patient relationship. Also, the increased use of technology demands a different and more advanced skill set. As you in Congress are well aware hospitals and their staff spend countless hours dealing with burdensome regulatory requirements and filling out paperwork. This takes nurses away from the bedside where they belong. There has also been an expansion of care delivery settings in which nurses can work, thereby spreading the existing workforce more thinly. Hospitals are now competing with home health agencies, health maintenance organizations, pharmaceutical companies, and recruitment firms to hire nurses and other providers.

Of course, while the job of a nurse has evolved, so too has the field of opportunity for women who traditionally filled these jobs. Fewer and fewer young women are entering the nursing profession, and to date there has been little success in reaching out to men and minorities to join the profession. According to a study by Peter Buerhaus, "Policy Responses to an Aging Registered Nurse Workforce," women graduating from high school in the 1990s were 35 % less likely to become RNs than women who graduated in the 1970's.

The decline in new nurse graduates in combination with the rapid aging of the existing pool of nurses and the aging population paint a picture of health care delivery in significant stress. The existing workforce shortage is projected to get much worse. Predictions for workforce employee vacancies are difficult to nail down, however, the Bureau of Labor Statistics states that 450,000 additional registered nurses will be needed to fill the present demand through the year 2008. According the General Accounting Office congressional testimony before the Senate Government Affairs Committee on June 27, 2001, "...Enrollments in registered nursing programs have declined over the last 5 years, shrinking the pool of new workers to replace those who are leaving or retiring. The problem is expected to be more serious in the future as the aging of the population substantially increases the demand for nurses."

The State of Florida

I would like to draw your attention to some specific examples within the state of Florida in order to illustrate the depth and breadth of the shortage. The Florida Hospital Association recently released their annual nurse staffing report which details the extent of the shortage in my state. Because of the shortage—the survey found that the use of temporary agencies was reported by 83% of the hospitals surveyed, and that 74% of those surveyed utilized nurse travelers and 73% used on-call staff. This is a growing phenomenon. The survey found that many hospitals used financial incentives including sign-on bonuses and seasonal bonuses. During the survey week of February 18th-24th of this year, the survey found that *3,087 RN positions were vacant within the hospitals surveyed.* This represents a 15.6% RN vacancy rate in the hospitals responding. (See attached chart #2.)

The problem is further detailed by studying the vacancy rates by RN Specialty. (See attached chart #3) Not only are we experiencing RN shortages in Florida at a rate of 15.6%, but hospitals are experiencing a shortage of Pediatric Critical Care nurses at a rate of 17.1%, Adult Critical Care nurses at 16.8%, and a shortage of Medical-Surgical nurses at a rate of 17.2%. These vacancy rates reflect a dramatic increase from rates just a year ago. The Pediatric Critical Care vacancy rate increased by an alarming 10%.

Experts agree that hospitals are competing with other health care providers for their workforce. In the state of Florida, the vast majority of nurses are still employed in the hospital setting—over 59% in the year 2000. The other practice set-

tings are: 18% in the community/home health arena, 10% in ambulatory care, 7% in nursing homes, 2% in nursing education and 4% in some other category. (See attached chart #4)

Bayonet Point

At my hospital, our current vacancy rate for RN's is between 25 and 27%, which translates into roughly 80 open RN positions. Currently, I have 14 RN's in specific training courses for specialties such as operating room and critical care nurses—that number would be double if I could find more nurses to undergo this training.

We have a number of recruitment efforts underway. HCA offers tuition reimbursement for all employees who pursue health care careers. Bayonet Point and seven other hospitals in our area have a new partnership with Pasco-Hernando Community College. We have agreed to fund additional teachers in the nursing school and have purchased the school a full-size mannequin as a teaching tool. In return, each hospital has the opportunity to provide scholarship money for up to 25 students at a time. Each student agrees to work for us for 2 to 3 years in return for the scholarship money—we have 16 students joining us in August.

Another outreach effort we have underway is educating career counselors at the junior high and high schools about the field of nursing and opportunities and careers within the health care field generally. We have found that many career counselors have little information about the career paths available.

Beyond recruitment, we must also focus on nurse retention. Bayonet Point has instituted bonus programs for staff to increase their working hours and we often modify work schedules to meet personal needs. We offer a variety of pay and incentive practices to meet the specific individual needs of our workers. One very important component of retaining nurses is asking their opinion. We seek out ways to involve nurses in care and treatment options and look for devices to reduce the difficult physical demands of the profession.

The issue we all face as nurses is that it is a physically demanding profession that requires night and weekend work. Our nurses are dealing with an increased acuity level, demanding patients and families and limited resources. My job as a CNO is to promote nursing as a rewarding career, listen to my staff, understand their concerns and work in partnership with them to resolve issues as quickly as possible.

SHORT TERM SOLUTIONS

Nurse Travelers and Staffing Companies

A side effect of workforce shortages is the development and growth of two staffing innovations: nurse travelers and nurse staffing agencies across the country. Although both entities have been in existence for a number of years, new companies are now recruiting thousands of traveler nurses who work at a facility for a period of months, weeks or days and then move on. These nurses travel the country to locations based on pay, specialty, weather, and whim. According to an article in *The New York Times* entitled "Nurse Shortage Puts a Premium on Staff Agencies", July 17, 2001, "Hospitals paid $7.2 billion last year for temporary employees, mainly nurses, according to *The Staffing Industry Report,* an industry news letter. And, spending on medical staffing is likely to increase more than 20% a year, it says, to $8.7 billion in 2001 and $10.6 billion next year."

A number of these traveler companies have begun initial public offerings of their stock and are doing quite well financially despite the downturn in the stock market. The industry report states that traveling nurse companies charge the hospitals between $40-$50 an hour, with higher hourly rates in high cost settings. As an added incentive to become a traveler, these companies frequently offer other benefits such as paid apartments, liability insurance, and health benefits for nurses who work a minimum period of time. An executive from one of the traveling companies based in Boca Raton, FL, Cross-Country TravCorps, estimated the ranks of traveling nurses have doubled in the past five years, with 15,000 nurses now crisscrossing the country. (*Washington Post* "Ranks of Traveling Nurses Grow" June 7, 2001)

Immigration

In addition to the growing utilization of nurse travelers and staffing agencies, a greater number of hospitals are recruiting their workforce abroad. I wanted to provide the subcommittee with some background information on the limited opportunities that we have to recruit and hire foreign nurses.

The main recruitment vehicle currently is the Labor Department's H1-C visa program. Regular green card applicant nurses are still coming into the United States, but at an extremely slow rate. The Department of Immigration is notorious for lengthy delays and time consuming processes that significantly slow any sort of reg-

ular influx of foreign nurses into the U.S. During the nursing shortage in the late 1980s, Congress created a special visa for nurses called the H-1A visa. Under the government program, the industry was able to recruit 6,000-7,000 nurses a year; the program expired in 1995.

Since 1995, Congress has not approved a comparable program. In fact, in late 2000, it expanded the number of visas that could be issued to recruit high-tech workers, but it overlooked healthcare. Congress passed the "Nursing Relief for Disadvantaged Areas Act" in 1999; however, it limits the number of foreign RNs to 500 per year. This legislation amended the Immigration and Nationality Act to establish a four-year nonimmigrant classification (H-1C) for nonimmigrant registered nurses in health professional shortage areas. The program was created as a temporary, limited solution and will expire in 2003.

The "Nursing Relief for Disadvantaged Areas Act" permits up to 500 foreign nurses to work in the U.S. per aggregate fiscal year. To qualify, hospitals must have at least 190 acute care beds, be located in federally designated areas with health care worker shortages, and meet thresholds on Medicare (35%) and Medicaid patient mix (28%.) Hospitals are also limited in how many nurses they can hire under this program based on the size of the state. According to the Department of Labor, only 14 hospitals benefited from this program. The law directs the Secretary of Health and Human Services to recommend 1) and alternative to the H-1C program as a permanent remedy to the registered nurse shortage; and 2) a more effective program enforcement system.

As mentioned above, there is some confusion regarding the H-1B Visa which was created to permit skilled foreign professionals to work in the U.S. for a period of up to six years. The H-1B Visa is also employer specific and is for "professional positions." Such positions are defined as specialty occupations that require critical and practical application of a body of highly specialized knowledge. Many medical and health occupations meet this definition, but foreign nurses are only eligible for H-1B status if the position would typically be filled by a nurse in a supervisory or research position. Due to the nursing shortages HCA hospitals are facing, Dr. Frank M. Houser, M.D., HCA's Senior Vice President, Quality, and Corporate Medical Director, just returned from travel to India in an effort to recruit nurses to work in our hospitals. However, as illustrated above, the opportunities for international recruitment are extremely limited because of existing immigration laws. The United States is also increasingly competing for nurses with other countries. For example, British hospitals, with the aid of their government, have already gotten a competitive advantage. Their recruitment offers include no visa requirements for degreed critical care Indian nurses willing to relocate to British hospitals.

LEGISLATIVE POSSIBILITIES FOR THE LONG TERM

Federation members have undertaken a wide range of innovative activities in order to recruit qualified nurses. But the problems of the shortage are so vast and complex that we are looking to Congress and the Administration to foster current activities, as well as provide support for further development and funding of nursing recruitment, education and retention.

As you know Mr. Chairman, a number of pieces of legislation have been introduced that attempt to increase the numbers of individuals entering the nursing field, by assisting with education and training, and also with retention of trained health care staff. Broadly, the Federation supports legislation that seeks to improve the following areas:

- *Recruitment*—We believe that federal leadership to promote and enhance the image of nursing would be very helpful. Many Federation members are already reaching out within their local communities to advance the public image of the profession, but increased federal attention to the critical role nurses play in our health care delivery system is key.
- *Faculty*—We recognize that in order to ensure a steady supply of the most qualified nurses we need to ensure the development and support of nursing faculty. Greater financial support of nursing programs is also important to ensure an adequately trained workforce.
- *Community Outreach*—We support federal grants that would foster innovative community/private partnerships in shortage areas. Examples of activities already undertaken by Federation members include outreach to vocational programs, partnering with nursing programs and providing sites for clinical rotations.
- *Nurse Service Corps*—The Federation supports the development of a nurse service corps that would allow loan repayment for nurses that serve in shortage areas/

facilities. Recruits for this program should be able to provide patient care in a wide range of settings irrespective of tax status.

- *Immigration*—Federal leadership to increase recruitment of nurses is critical, but just as critical is modifying immigration laws to allow more nurses to come to the United States from abroad. Current immigration laws severely limit the number of nurses who can be recruited internationally. Further slowing down the process is the Department of Immigration and Naturalization Services which delays legal immigration for months at a time. We ask Congress to review the current visa programs for nurses and consider expanding the existing H-1C visa program and/or reauthorizing the H-1A program. Immigration reform could help alleviate some of our staffing shortages in short order.

Specifically, members of this Committee have introduced legislation that would attempt to increase the numbers of workers entering the nursing workforce and provide opportunities and incentives to alleviate the shortage. The "Nurse Reinvestment Act"—H.R. 1436 was introduced by Representatives Lois Capps (D-CA) and Susan Kelly (R-NY). This legislation would foster community partnerships and innovative programs for recruitment. The bill would also develop a national nurse service corps. We believe that this legislation has many valuable ideas and could serve as a starting point, however it falls short because it does not ensure that nurses could work in the facility of their choice. Specifically, all Federation member facilities would be excluded from using the Nurse Service Corps, as well as the other sections of the bill. We would like to work with Representative Capps and Kelly to amend the legislation to ensure that their creative solutions to the workforce crisis are helpful to all hospitals.

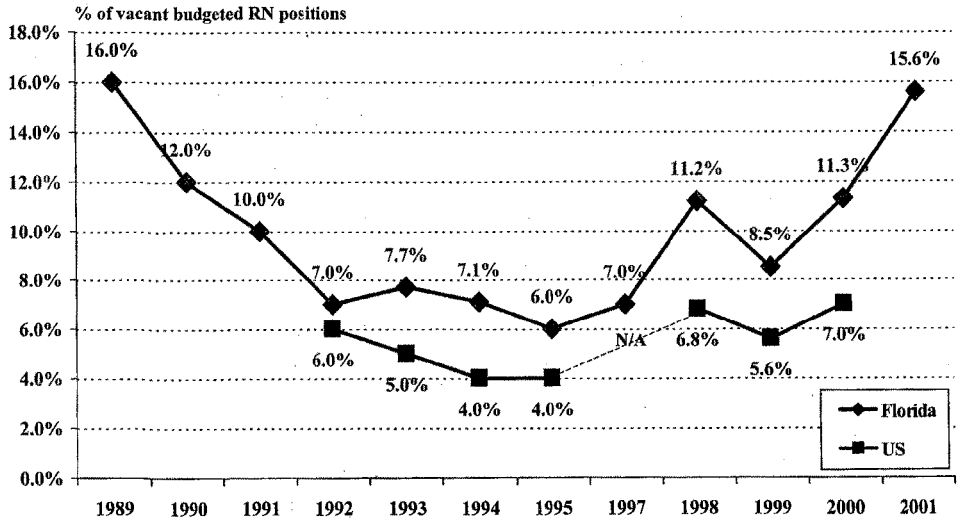
The other promising piece of legislation introduced by members of this Committee is the "Nurse of Tomorrow Act of 2001" H.R. 1897 introduced by Representatives Eliot Engel (D-NY) and Mary Bono (R-CA). HR 1897 would authorize the Secretary of HHS to make grants to health care facilities for nurse recruitment and retention activities, as well as encourage facilities to assist in nurse education and training. The bill also establishes refundable tax credits for nurses. The Federation supports the ideas embodied in HR 1897, and applauds the bill's sponsors for including all facilities in their legislation.

CONCLUSION

CNO's are a passionate lot who firmly believe in the profession of nursing. They work continuously to support their staff and to provide them with the tools they need to deliver care. I have been a nurse for over 30 years and, frankly, cannot imagine doing anything else. Federation members and all healthcare facilities are facing a workforce crisis. Our hospitals are on the front lines of delivering patient care, but our most precious resource, our workers are in very short supply. We look forward to working with Congress and the Administration to attempt to solve this complex and growing problem.

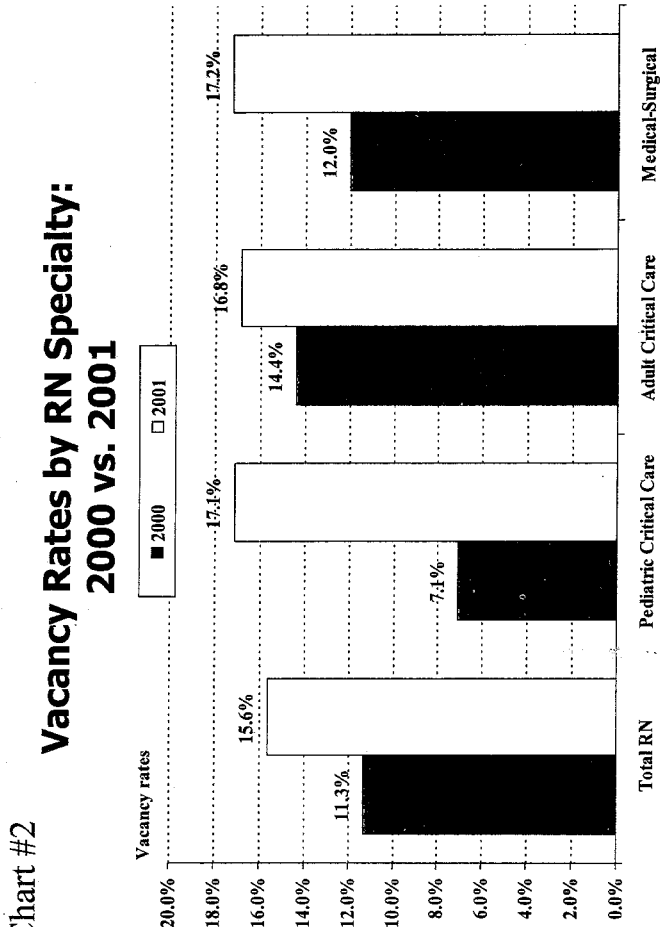
Chart #1

RN Vacancy Rates in Florida: 1989 - 2001



Survey was not conducted in 1996, and US data is not available for 1997.
Vacancy rates reflect the percentage of budgeted positions that are not filled.
Sources: FHA Nurse Staffing Surveys, 1989 - 2001, NAHCR, 2000

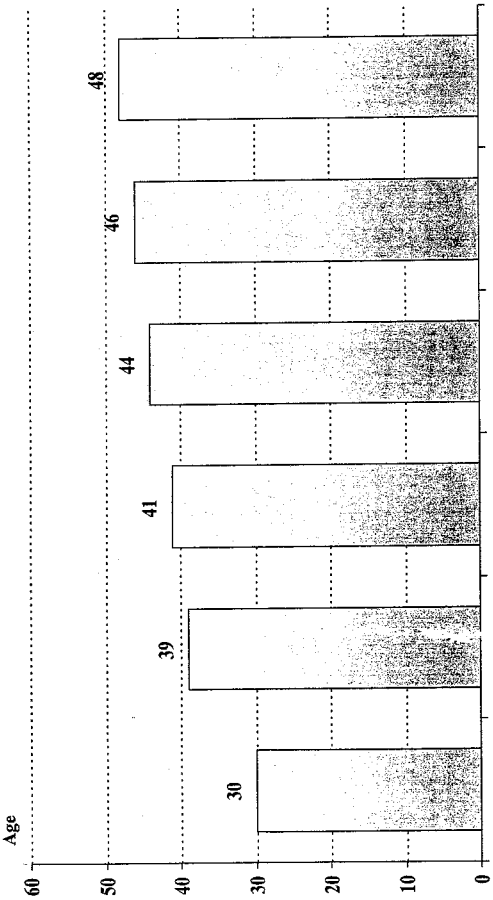
Chart #2



Source: FHA Nurse Staffing Survey Reports, 2000 and 2001

Chart #3

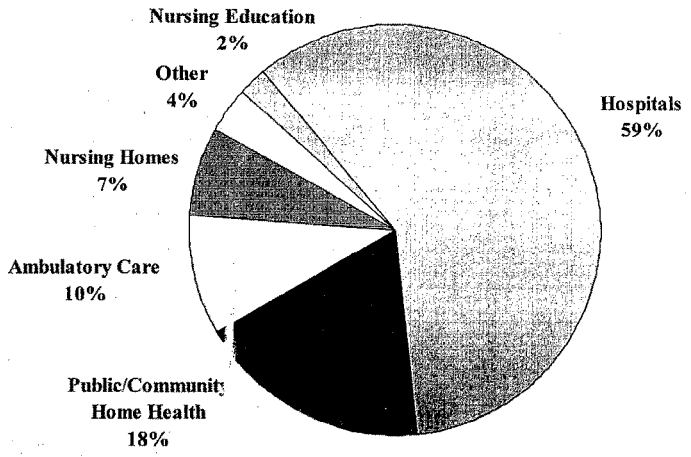
Average Age of Nurses, US: 1981 - 2000



Sources: American Organization of Nurse Executives, 2000
HRSA Division of Nursing, 2001

Chart #4

Florida RNs by Employment Setting: 2000



Source: HRSA State Health Workforce Profiles and Bureau of Health Professions, Feb. 2001

Mr. BILIRAKIS. Thank you very much.
Ms. Baker.

STATEMENT OF DIANA BAKER

Ms. BAKER. Good afternoon, Mr. Chairman and members of the subcommittee. My name is Diana Baker. I am a Registered Nurse employed as an Assistant Nurse Manager at the Cleveland Clinic Foundation in Cleveland, Ohio. I am pleased to be here today representing the American Nurses Association in support of your efforts to improve the recruitment and retention of America's registered nurses. ANA is the only full-service association representing the Nation's RNs. I am a member of the Ohio Nurses Association, one of the 54 constituent members of the ANA.

As this subcommittee is very aware, health care institutions across the Nation are experiencing a crisis in nurse staffing, and we are facing an unprecedented nursing shortage. As RNs are the largest single group of health care professionals in the United States, nursing shortages pose a real threat to our Nation's health care system.

There has been some debate about the extent of the current nursing shortage. Some say it is economic and some say it is regional, while others say it is national. One thing is certain, the current staffing shortage is nothing in comparison to the systemic shortage that will become a reality in the next 8 to 10 years.

Today's nursing shortage is compounded by the lack of young people entering the nursing profession, the rapid aging of the RN workforce, and the impending health care needs of the Baby Boom generation. As new opportunities have opened up for young women and new stresses have been added to the profession of nursing, fewer people have opted to choose nursing as a career. New admissions into nursing schools have dropped dramatically and consistently for the past 6 years.

The lack of young people entering nursing has resulted in a steady increase in the average age of the working nurse. Today, the average working RN is over 43 years old. The national average is projected to continue to increase until 2010. At that time, large numbers of nurses are expected to retire and the total number of nurses in America will begin a steady decline.

At the same time, the demand for nursing care will increase over the next 20 years due to the aging of the population, advances in technology and other economic and policy factors. These combining demographic forces will soon create a true, systemic nursing shortage. Current estimates state that the number of nurses per capita will fall 20 percent below requirements by the year 2020.

Now is the time to address this impending public health crisis. The Nurse Education Act programs administered through the Division of Nursing at the Health Resources and Services Administration are designed to ensure an adequate supply of nurses in underserved areas throughout the Nation. These programs have greatly impacted the nurse workforce and have enjoyed substantial congressional support. Building on these programs is the best way to address concerns about the lack of people entering nursing.

More specifically, ANA strongly supports the Nurse Reinvestment Act which was drafted by a member of this subcommittee,

Representative Lois Capps, a fellow nurse. This comprehensive bill addresses many issues in nurse education and will greatly help recruitment into the profession. It enjoys the broad support of nurses as well as institutional providers and educators.

My written statement contains a more complete summary of this bill. Let me just say here that the combination of innovative recruitment techniques, curriculum support, scholarships, and loan repayments contained in the Nurse Reinvestment Act will enhance all aspects of nurse education.

In addition to nurse recruitment programs, I urge this subcommittee to take a deeper look into the nurse workforce issues. It is important to realize that demographics are not the one and only cause of the emerging nursing shortage. The General Accounting Office, the Congressional Research Service, academia and private market research have all published reports this year that cite nurse dissatisfaction as a major contributor to the current and emerging shortage. Dissatisfaction is prompting experienced nurses to leave the profession and discouraging young people from entering.

I know that when I was a nursing student, working nurses would approach me and ask me, "Why do you want to be a nurse, all we do is get overworked, and we are underpaid", a clear sign of dissatisfaction. My written statement more fully examines the causes for nurse dissatisfaction.

Let me summarize by stating that nurses will remain reluctant to accept positions in which we face inappropriate staffing, are confronted by mandatory overtime, are inappropriately rushed through patient care activities, or are otherwise unable to provide the high quality care that we are trained to give.

I encourage this committee to act now to support the Nurse Reinvestment Act. The very fabric of our safety net programs rely on an adequate supply of well-trained nurses, but we cannot stop there. The fact is that the current nursing shortage will remain and likely worsen if changes to the workplace are not all addressed.

Thank you for the opportunity to provide this testimony. I am happy to answer any questions.

[The prepared statement of Diana Baker follows:]

PREPARED STATEMENT OF DIANA BAKER ON BEHALF OF THE AMERICAN NURSES ASSOCIATION

Good morning Mr. Chairman and Members of the Subcommittee. I am Diana Baker, RN, an assistant nurse manager on the urology/gynecology unit at the Cleveland Clinic in Cleveland, Ohio. I am pleased to be here today representing the American Nurses Association (ANA) in support of your efforts to improve the recruitment and retention of America's registered nurses (RNs). ANA is the only full-service association representing the nation's RNs. I am a member of the Ohio Nurses Association, one of the 54 constituent member nurse associations of the ANA.

As this Committee is aware, health care institutions across the nation are experiencing a crisis in nurse staffing, and we are standing on the precipice of an unprecedented nursing shortage. The current and emerging shortage of RNs poses a real threat to the nation's health care system. RNs are the largest single group of health care professionals in the United States; we underpin the entire health care delivery system.

The Nurse Education Act programs administered through the Division of Nursing at the Health Resources and Services Administration are designed to ensure an adequate supply of nurses in under served areas throughout the nation. These pro-

grams have greatly impacted the nurse workforce and have enjoyed substantial Congressional support. Building on these programs is the best way to address the concerns that we have all been hearing about the growing nursing shortage.

The extent of the concern about this emerging shortage underscores the fact that having a sufficient number of qualified nurses is critical to the health of our nation. ANA can assure you that the emerging nursing shortage is very real and very different from any experienced in the past. Hospitals, long term care facilities and other health care providers across the nation are reporting problems filling nursing positions. Employers are having difficulty finding experienced nurses, especially in emergency departments, critical care, labor and delivery, and long term care, who are willing to work in their facilities. Press reports about emergency department diversions and the cancellation of elective surgeries due to short staffing are becoming commonplace. In addition, projections show that these current shortages are just a minor indication of the systemic shortages that will soon confront our health care delivery system.

It is important to realize that the causes, and therefore the answers, for the emerging nursing shortage are complex and interrelated. It is critical to examine issues in education, health delivery systems and the work environment. ANA maintains that the reasons for the current nurse vacancy rates and the impending shortage are multifaceted. Therefore, we must approach this shortage from many fronts.

THE EMERGING NURSE SHORTAGE

The current nursing shortage is compounded by the lack of young people entering the nursing profession, the rapid aging of the RN workforce, and the impending health care needs of the baby boom generation. As new opportunities have opened up for young women and new stresses have been added to the profession of nursing, fewer people have opted to choose nursing as a career. New admissions into nursing schools have dropped dramatically and consistently for the past six years.

The lack of young people entering nursing has resulted in a steady increase in the average age of the working nurse. Today, the average working RN is over 43 years old. The national average is projected to continue to increase until 2010. At that time, large numbers of nurses are expected to retire and the total number of nurses in America will begin a steady decline.

At the same time, the need for complex nursing services is expected to increase. America's demand for nursing care is expected to balloon over the next 20 years due to the aging of the population, advances in technology and various economic and policy factors. In fact, the Bureau of Labor Statistics ranks the occupation of nursing as having the seventh highest projected job growth in the United States.

The increasing demand for nursing services, coupled with the imminent retirement of today's aging nurse, will soon create a systemic nursing shortage. A recent study published in the *Journal of the American Medical Association* estimates that the overall number of nurses per capita will begin to decline in 2007, and that by 2020 the number of nurses will fall nearly 20 percent below requirements.

Now is the time to address this impending public health crisis. ANA strongly supports the Nurse Reinvestment Act (S. 706, H.R. 1436), which was drafted by a member of this Subcommittee—Representative Lois Capps, a fellow nurse. This comprehensive bill addresses many issues in nurse education and will greatly aide recruitment into the profession. It enjoys the broad support of practicing nurses throughout the nation as well as institutional providers and educators.

The Nurse Reinvestment Act contains funding for public service announcements to educate the public about the many rewards of a nursing career. It supports grants for health career academies to create partnerships between health care facilities, nursing schools, and high schools to introduce high school students to nursing curriculum. The bill provides nursing recruitment grants to support outreach programs in primary, junior, and secondary schools and to support nursing students. It establishes a new nurse corps to provide educational scholarships in exchange for commitment to serve in a health facility determined to have a critical shortage of nurses. It supports career ladder grant program to assist individuals, health care providers and schools of nursing to enable the nursing workforce to obtain continuing education—and, importantly, fosters the development of nursing faculty needed to teach these students. It directs the Secretary of HHS to establish rules for making payments to non-hospital-based, federally certified hospice programs and home health agencies for the reasonable costs of providing nurse training, and reauthorizes and modifies the federal Medicaid match for nursing home clinical education of nurses.

The comprehensive combination of innovative recruitment techniques, curriculum support, scholarships, and loan repayments will enhance all aspects of nurse edu-

cation. ANA wholeheartedly agrees that the solution to the nursing shortage lies in the further development of our nation's existing nurse population and the cultivation of our youth into this very worthwhile profession.

RECENT CHANGES IN NURSE EMPLOYMENT

In addition to enhanced nurse education programs, ANA urges this Subcommittee to take a deeper look into nurse workforce issues. It is important to realize that demographics are not the only cause for the emerging nursing shortage. Current staffing problems are inexorably tied to changes in nurse employment practices over the last decade.

Just ten years ago we were emerging from the nursing shortage of the late 1980's. Nursing workforce issues had caught the attention of the highest reaches of the Reagan and Bush Administrations and the HHS Secretary's Commission on Nursing had recently released recommendations on methods to improve the work environment for nurses. Very few of these workplace initiatives were actually implemented, but health care facilities across the nation did institute aggressive recruitment campaigns and wages were increased. By the early 1990's reports of nurses shortages had significantly diminished.

Unfortunately, the picture changed abruptly in the mid-1990's. At this time, managed care began to exert downward pressure on provider margins. In addition, the impact of Medicare prospective payment was taking hold. In response to financial pressures, providers eagerly sought out and implemented programs designed to reduce expenditures. New models of health care delivery were implemented, and highly trained, experienced—and therefore higher paid—personnel were eliminated or redeployed. As RNs typically represent the largest single expenditure for hospitals (averaging 20 percent of the budget), we were some of the first to feel the pinch. Lesser-skilled, lower-salaried assistive staff were hired as replacements, and RN salaries decreased in both actual and real terms.

Analysis of census data shows that between 1994 and 1997 RN wages across all employment settings dropped by an average of 1.5 percent per year (in constant 1997 dollars). Between 1993 and 1997, the average wage of an RN employed in a hospital dropped by roughly a dollar an hour (in real terms). RN employment in the hospital sector reversed to the negative. Many providers eliminated positions for nursing middle managers and executive level staff. Hospital employment for unlicensed aides, however, increased by an average of 4.5 percent a year between 1994 and 1997.

The Current Employment Situation

These recent changes in nurse employment served to increase the pressure on staff nurses who were required to oversee unlicenced aides while caring for a larger number of sicker patients. The elimination of management positions shortened the career ladder and decreased the support, advocacy and resources necessary to ensure that nurses could provide optimum care. At the same time employment security was uncertain and wages were being cut. Numerous studies reveal that these recent changes in RN employment have negatively impacted patient care, the work environment for nurses, the perception of nursing as a career, and the staffing flexibility needed to address temporary staffing shortages.

Not surprisingly, these changes have precipitated the current downturn in the number of people choosing the nursing profession, and growing discontent among those who remain. A recent ANA survey revealed that nearly 55 percent of the nurses surveyed would not recommend the nursing profession as a career for their children or friends. In fact, 23 percent of the respondents indicated that they would actively discourage someone close to them from entering the nursing profession. I know that when I was a nursing student, working nurses would approach me and advise me to find another career—a clear sign of dissatisfaction.

A large multi-national survey recently conducted by the University of Pennsylvania's Center for Health Outcomes and Policy Research shows that America's nurses are particularly dissatisfied. More than 40 percent of nurses in American hospitals reported being dissatisfied with their jobs, as compared to 15 percent of all workers. In addition, this report shows that 43 percent of American nurses score higher than expected on measures of job burnout. It is a sad fact that staff nurses typically burn out and leave hospital bedside nursing after just four years of employment.

This discontent is prompting an alarming number of our experienced RNs to abandon nursing. The 2000 National Sample Survey of Registered Nurses shows that a large number of nurses (500,000 nurses—more than 18 percent of the total nurse workforce) who have active licenses are not working in nursing. Clearly, something in the practice setting is driving these nurses away from their chosen profession.

Recent reports by the General Accounting Office, the Congressional Research Service, academia and private market research indicated that job dissatisfaction is a major factor contributing to the current nursing shortage. Nurses are, understandably, reluctant to accept positions in which we will face inappropriate staffing, be confronted by mandatory overtime, inappropriately rushed through patient care activities, and unable to provide the high quality care that we were trained to give.

SOLUTIONS

ANA is supporting an integrated state and federal legislative campaign to address the many components of the current and impending nursing shortage. Key among these is strong support for recruitment and education initiatives such as the Nurse Reinvestment Act. In addition, we are also supporting improvements to organization of the work of nursing. ANA understands that in addition to attracting more young people to the profession, we must also create a environment that fosters the retention of our experienced nurses. Following are two workplace initiatives we hope this Committee will consider.

Adequate Staffing

The safety and quality of care provided in the nation's health care facilities is directly related to the number and mix of direct care nursing staff. More than a decade of research shows that nurse staffing levels and skill mix make a difference in the outcomes of patients. Studies show that when there are more nurses, there are lower mortality rates, shorter lengths of stay, better care plans, lower costs, and fewer complications. In fact, four HHS agencies—the Health Resources and Services Administration, Health Care Financing Administration, Agency for Healthcare Research and Quality, and the National Institute of Nursing Research of the National Institutes of Health—recently sponsored a study on this very topic. The resulting report, released on April 20, 2001, found strong and consistent evidence that increased RN staffing is directly related to decreases in the incidence of urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and decreased hospital length of stay.

In addition to the important relationship between nurse staffing and patient care, several studies have shown that one of the primary factors for the increasing nurse turnover rate is dissatisfaction with workload/staffing. ANA's recent survey states that 75 percent of nurses surveyed feel that the quality of nursing care at the facility in which they work has declined over the past two years. Out of nearly 7,300 respondents, over 5,000 nurses cited inadequate staffing as a major contributing factor to the decline in quality of care. More than half of the respondents believed that the time they have available for patient care has decreased.

The University of Pennsylvania research shows that 70-80% of more than 43,000 registered nurses surveyed in five countries reported that there are not enough RNs in hospitals to provide high quality care. Only 33 percent of the American nurses surveyed believed that hospital staffing is sufficient to "get the work done." This survey reflects similar findings from a national survey taken by the Henry J. Kaiser Family Foundation (1999) that found that 69 percent of nurses reported that inadequate nurse staffing levels were a great concern. The public at large should be alarmed that more than 40 percent of the nurses who responded to the ANA survey stated that they would not feel comfortable having a family member cared for in the facility in which they work.

Adequate staffing levels allow nurses the time that they need to make patient assessments, complete nursing tasks, respond to health care emergencies, and provide the level of care that patients deserve. It also increases nurse satisfaction and reduces turnover. For these reasons, ANA supports efforts to require acute care facilities to implement and use a valid and reliable staffing plan based on patient acuity as a condition of participation in the Medicare and Medicaid programs. In addition, we support efforts to enhance the current minimum nurse-to-patient staff ratios in skilled nursing facilities.

Mandatory Overtime

ANA is concerned that nurses across the nation are expressing concerns about the dramatic increase in the use of mandatory overtime as a staffing tool. ANA understands that overtime is the most common method facilities are using to cover staffing insufficiencies. Employers may insist that a nurse work an extra shift (or more) or face dismissal for insubordination, as well as being reported to the state board of nursing for patient abandonment. Concerns about the use of mandatory overtime are directly related to patient safety.

It is well established that sleep loss influences several aspects of performance, leading to slowed reaction time, failure to respond when appropriate, false re-

sponses, slowed thinking, and diminished memory. In fact, 1997 research by Dawson and Reid at the University of Australia showed that work performance is more likely to be impaired by moderate fatigue than by alcohol consumption. Their research highlights the fact that significant safety risks are posed by workers staying awake for long periods. It only stands to reason that an exhausted nurse is more likely to commit a medical error than a nurse who is not being required to work a 16 to 20 hour shift.

Nurses are placed in a unique situation when confronted by demands for overtime. Ethical nursing practice prohibits nurses from engaging in behavior that we know could harm patients. At the same time, RNs face the loss of their license—our careers and livelihoods—when charged with patient abandonment. Absent legislation, nurses will continue to confront this dilemma. For this reason, ANA supports legislative initiatives to ban the use of mandatory overtime through Medicare provider agreements.

I can tell you that I have made the personal decision not to use mandatory overtime to meet staffing needs in my unit because I believe that it fosters an environment rich for medical error and contributes to nurse turnover. My experience as a staff nurse and an assistant nurse manager has taught me that mandatory overtime is not a safe or viable staffing option.

CONCLUSION

ANA and I encourage this Committee to act now to support the Nurse Reinvestment Act. The very fabric of our safety net programs rely on an adequate supply of well-trained nurses. We can not stop there, however. The fact is that the current nursing shortage will remain and likely worsen if changes to the workplace are not immediately addressed. The profession of nursing will be unable to compete with the myriad of other career opportunities available in today's economy unless we improve working conditions. Registered nurses, hospital administrators, other health care providers, health system planners, and consumers must come together in a meaningful way to create a system that supports quality patient care and all health care providers.

ANA looks forward to working with you and our industry partners to make the current health care environment conducive to high quality nursing care. Improvements in the environment of nursing care, combined with aggressive and innovative recruitment efforts will help avert the impending nursing shortage. The resulting stable nursing workforce will support better health care for all Americans.

Mr. BILIRAKIS. Thank you very much, Ms. Baker.

Dr. Roberts, you are up, sir.

STATEMENT OF CORY A. ROBERTS

Mr. CORY ROBERTS. Chairman Bilirakis, Congressman Brown, members of the subcommittee, my name is Cory Roberts, and I am a Board-certified pathologist and Director of Anatomic Pathology at St. Paul Medical Center in Dallas, Texas. I am here today representing the American Society of Clinical Pathologists and I formerly served as a liaison member to its Board of Directors.

You may ask why a pathologist is here to discuss non-physician personnel shortage issues. ASCP is a unique organization, and we have 75,000 members. Of those members there are Board-certified pathologists, other physicians, clinical scientists, as well as medical technologists and technicians. Our certifying board registers over 150,000 laboratory personnel every year.

I am here to attest to the shortage, provide you with data regarding this, as well as explain the workforce shortage problem.

The United States is approaching a serious shortage of laboratory personnel with vacancy rates for seven of ten key laboratory positions at an all-time high. Vacancy rates for cytotechnologists, the professionals who evaluate Pap smears and other cytological material, as well histotechnologists who prepare tissue specimens for evaluation, are at an alarming high of over 20 percent.

The American Society of Clinical Pathologists' Board of Registry, in conjunction with an independent polling firm, MORPACE, out of Detroit, conducts a biennial wage and vacancy survey, and has since 1988. We survey over 2500 medial laboratory managers. This measures the vacancy for these ten key laboratory personnel positions, and compares and contrasts these data with the previous year's. The data for 2000 was published in the March 2001 issue of the Journal of Laboratory Medicine, and I would like to give you a glimpse of what we found.

Vacancy rates for cytotechnologists in the northeast average 45 percent, in the east north central region it was almost 17 percent, and the far west region showed 33 percent. Rural areas overall averaged a 20-percent vacancy rate, and large cities a surprising over 28 percent. Private reference laboratories have an average vacancy of 20 percent for histotechnologists, while hospitals have almost 38 percent vacancy rate for these same people.

By comparison, the vacancy rate for medical technologists may not appear to be such a problem, however, it, too, is worthy of concern. Vacancy rate overall for medical technologists averages 11 percent.

While the supply of laboratory personnel is dwindling, the demand for these professionals is continuing to increase, as evidence, in part, by rising wages.

Median average pay rate increases from 1998 to 2000 were larger than comparisons for any other time period in our study. Only two laboratory professions had wage increases of less than 10 percent, and even those were over 8 percent. The histotechnologists led the way at 15.4 percent.

In Dallas, where I practice, we currently have openings for 12 medical technologists within the University of Texas Southwestern system, which includes my St. Paul Medical Center. We also have five histotechnologist openings, that, in spite of our offering signing bonuses as well as a recent across-the-board 10 percent pay raise to our histotechnologists. I don't want to give too many more specifics simply because of the fierce competition among the hospitals in the region for this limited pool of applicants.

One of the logical solutions to this would be to simply train more professionals for these positions. That said, the programs are in fact decreasing in number. For example, in Michigan, the number of programs for medical technologists has decreased from 27 to 8 in less than two decades. In California, with its large population base, there are only two programs in the entire State to train cytotechnologists.

According to the Health Professions Education Directory published by the American Medical Association, from 1994 to 1999, the number of programs and the number of graduates for medical technologists has decreased by 30 percent.

There are several reasons why the vacancy rate is increasing. Some program directors report that their graduates are taking positions outside of the traditional laboratory with companies that are involved with laboratory information systems, dot.coms, and corporations that manufacture or distribute diagnostic reagents, supplies and materials.

With limited resources, hospitals have merged, thus decreasing the opportunities for training sites for medical laboratory programs. Yet, the continued demand for laboratory services is real and, in fact, will probably grow. For example, in Florida, the population by the year 2020 is projected to grow by 29 percent. Those over age 65, though, will grow at a rate of 66 percent. This disproportionate growth of those over 65 is borne out in other States as well.

Given the country's aging population, the number and complexity of biopsy specimens and the use of molecular techniques will likely increase during the next decade. The average age for a medical technologist currently is 45, many are approaching retirement. The threat of bioterrorism calls for trained laboratory professionals to respond. The laboratory workforce will have to be able to react accordingly with appropriate numbers of trained professionals.

I greatly appreciate this opportunity to discuss this problem with you all today. As a practicing pathologist, who works with a team of medical professionals including medical technologists and technicians, I know there is a growing concern over this problem, and the facts bear this to be true. Thank you again for your time and consideration.

[The prepared statement of Cory A. Roberts follows:]

PREPARED STATEMENT OF CORY ROBERTS, DIRECTOR OF ANATOMIC PATHOLOGY, ST. PAUL MEDICAL CENTER ON BEHALF OF THE AMERICAN SOCIETY OF CLINICAL PATHOLOGISTS

Chairman Bilirakis, Congressman Brown, members of the Subcommittee, my name is Cory Roberts, MD, FASCP. I am a pathologist serving as Director of Anatomic Pathology at St. Paul Medical Center in Dallas, Texas, and also am a partner at ProPath Associates in Dallas. I am here today representing the American Society of Clinical Pathologists (ASCP) where I served as a liaison member to its Board of Directors.

You may ask why a pathologist is here to discuss the shortage of non-physician medical laboratory personnel. Well, ASCP is a unique organization. It is a nonprofit medical specialty society organized for educational and scientific purposes. Its 75,000 members include board certified pathologists, other physicians, clinical scientists, and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel. ASCP's certifying board registers more than 150,000 laboratory professionals annually.

I am here to attest to the shortage, provide you with national data on the subject as well as an explanation for this workforce shortage problem. Finally, I would like to outline some current solutions to this growing concern.

The Problem

The United States is approaching a serious shortage of laboratory medical personnel with vacancy rates for seven of ten key laboratory medicine positions at an all time high. Vacancy rates for cytotechnologists, the professionals who evaluate Pap smears and other cellular material, and histotechnologists, the individuals who prepare tissue specimens for cancer biopsies, are at an alarming high of over 20%.

The American Society of Clinical Pathologists' Board of Registry, in conjunction with MORPACE International, Inc., Detroit, conducts a biennial wage and vacancy survey of 2,500 medical laboratory managers. The survey measures the vacancy rates for 10 medical laboratory positions, and compares and contrasts these data with that from 1988, 1990, 1992, 1994, 1996, and 1998 studies. The data for 2000 was published in March 2001, and I'd like to give you a glimpse of what was found.

Vacancy rates for cytotechnologists in the northeast average 45 percent, 16.7 percent for the east north central, and 33.3 percent for the far west. Rural areas average a 20 percent vacancy rate for cytotechnologists, and large cities a rather surprising 28.3 percent rate.

Private reference laboratories have an average vacancy rate of 20 percent for histotechnologists, and hospitals have a 37.7 percent shortage of the same profession.

The west south central region of the country has a 73.7 percent vacancy rate for histotechnologists, and the south central Atlantic states have an average vacancy rate of 16.7 percent.

By comparison, the vacancy rate for medical technologists will not appear to be a problem, but it too is reason for concern. Medical technologist vacancy rate averages 11.1 percent, but rural areas show 21.1 percent vacancy and hospitals with 100-299 beds have a rate of 17.6 percent.

While the supply of laboratory personnel is dwindling, the demand for these professionals is increasing—as evidenced, in part, by the rise in wages.

Beginning wage increases from 1998 to 2000 were the largest experienced since comparisons from the 1990 to 1992 studies. Pay for nine of the 10 employee positions increased at least 6.9% from 1998 to 2000, with histotechnologist pay increasing 15.8%. Median average pay rate increases from 1998 to 2000 were larger than comparisons for any other time period. Only medical technologist supervisors (at 8.6%) and medical laboratory technician staff (at 8.5%) had wage increases of less than 10%. Histologic technicians (at 13.3%) and histotechnologists (at 15.4%) experienced the largest increases.

In Dallas, where I practice, we currently have 12 positions available for medical technologists within the University of Texas Southwestern medical system (this includes Parkland Memorial Hospital and St. Paul Medical Center). There are 5 histotechnologist positions available. We offer signing bonuses and increased wages to attract laboratory personnel to our facility. I am reluctant to mention exactly what we offer because, frankly, laboratory personnel are in such demand that neighboring health care institutions will often "one-up" each other in order to draw from the same pool of applicants.

Medical Laboratory Programs

One of the logical solutions to this vacancy rate problem is to train more students; however, the number of programs are decreasing. For example, in Michigan, we have seen the number of programs plummet from 27 to 8 in less than two decades. In California, there are no programs available for histologic technicians or specialists in blood banking. There are only two programs for cytotechnologists, one program for medical laboratory technicians, and one for phlebotomists in that entire state.

It is important to note that education programs for training medical laboratory personnel are sponsored by a variety of organizations and institutions, ranging from hospitals to degree-granting colleges and universities.

According to the *Health Professions Education Directory* published by the American Medical Association, the number of medical technology programs decreased from 383 in 1994 to 273 in 1999. The number of graduates in medical technology has similarly decreased from 3563 in 1994 to 2491 in 1999, a 30 percent decline in five years.

Assessment

There are several reasons why the vacancy rate is increasing and the number of program enrollees is decreasing. A number of available positions are outside the traditional clinical laboratory. Some program directors have reported that graduates are gaining employment in laboratory information systems companies, "dot.coms," and corporations that manufacture or distribute diagnostic reagents, supplies or equipment. With limited resources, hospitals have merged, thus decreasing the availability of training sites for medical laboratory programs. Some programs have responded by increasing access to other laboratory training sites, such as forensics laboratories, blood centers, physician offices, and outpatient clinics. Yet, with these shifts, the continued demand for laboratory services is real and is expected to grow.

In Florida, according to the Bureau of the Census, the population is projected to grow by 29% by 2020, and the population over age 65 is projected to grow by 66% in the same time period. In Ohio, the population is projected to grow by 3% by 2020, and the population over age 65 is projected to grow by 34% in the same time period.

Given the country's aging population, the number and complexity of biopsy specimens and the use of molecular techniques will likely increase during the next decade. Laboratory professionals who entered the workforce in the 1960s and 1970s will be retiring soon as the average age for a medical technologist now is 45 years old. The threat of bioterrorism calls for trained laboratory professionals to respond. The laboratoryallied health workforce will need to be able to react accordingly with appropriate numbers of trained and educated personnel.

Current Working Solutions

There are solutions to these problems. As a professional organization, ASCP believes it holds a responsibility to address the workforce shortage. As such, ASCP offers scholarships to medical laboratory technology students each year to relieve some of the financial burden of higher education, but this does not come close to fulfilling the need. We produce career brochures and audiovisual materials for high school students and younger children to learn about opportunities in the laboratory. ASCP also exhibits and advertises at the annual conference for the National Association of Biology Teachers in an attempt to help these educators guide interested students to careers in the laboratory.

On the public side, there are grants available to help attract laboratory professionals to the field, especially minorities and individuals in rural and underserved communities. The Allied Health Project Grants program, administered by the Health Resources and Services Administration, has been successful in effectively attracting new allied health professionals into the laboratory field.

For example, the University of Nebraska Medical Center, my alma mater, established medical technology education sites in four communities in rural Nebraska, including a student laboratory in central Nebraska, under an Allied Health Project Grant. As of 1999, of 69 graduates, 99% took their first job in a rural community, and 74% took their first job in rural Nebraska.

The grants are also designed to create successful minority recruiting and retention programs for medical technologists. This was the focus of a University of Maryland, Baltimore project initiated by allied health grant funding in 1991. Through utilizing a four phase design, which begins with career awareness activities for elementary and middle school students, this model provides a continuum of activities that progressively focuses on identifying, retaining, and advancing interested students to the completion of a baccalaureate degree. Because of this program, the University of Maryland, Baltimore has attained a current 70% minority medical technology student enrollment at a majority institution, and an average 89% student retention rate, placing it among the highest in the country. 95% of the graduates of this program receive immediate placement.

Most allied health grant projects continue after federal funding ends, making them a longlasting, worthwhile investment in the future of allied health.

I greatly appreciate this opportunity to discuss this concern over the medical laboratory personnel shortage with you. As a practicing pathologist, who works as part of the laboratory team with medical technologists and technicians, I know there is a growing concern over this shortage and the data certainly bears this to be true. Thank you again for your time and consideration.

Mr. BILIRAKIS. Thank you very much, Dr. Roberts.

Ms. Pietrantoni. Did I pronounce that all right?

STATEMENT OF ADELE PIETRANTONI

Ms. PIETRANTONI. Very close.

Mr. BILIRAKIS. In other words, no.

Ms. PIETRANTONI. Good afternoon, Mr. Chairman, Ranking Member Brown, and members of the subcommittee. Thank you for the opportunity to present the views of pharmacist caregivers in hospitals, long-term care facilities, community pharmacies and other practice settings across the country.

My name is Adele Pietrantoni. I am a pharmacist, immediate part President and current Chair of the Massachusetts Pharmacists Association, and am currently a trustee for the American Pharmaceutical Association, the national professional society of pharmacists.

I am here to speak about the acute shortage of pharmacists in the United States today. In December of 2000, HRSA released a report identifying and quantifying the degree of the current shortage. A shortage of pharmacists is a serious problem, as pharmacists are a valuable resource for ensuring the safety, efficacy, and cost-effectiveness of medication therapy for the millions of Americans who rely on medications to cure disease, resolve symptoms and main-

tain health. Nurses provide the most public face in the health care system and medical technologists perform vital functions to support the system, pharmacists are the patient's last line of defense to ensure the appropriate use of medications. Pharmacists work with patients to ensure that medications work, and to minimize the situations where this valuable technology causes harm.

The shortage stems from a hyper-demand for medication and medication therapy management services. This demand is evident in the dramatic growth in the number of prescriptions prepared daily, growth that is sure to continue, and the significant expansion of the pharmacist's role in patient care. As the population ages, the shortage of pharmacists and other health care professionals will continue. Congress can play a valuable role in helping address this serious issue.

According to the HRSA study, the number of prescriptions dispensed in ambulatory settings increased 44 percent between 1990 and 1999. The number of pharmacists per 100,000 people, a standard measurement, rose 5 percent in that period, and this level of growth is expected to remain the same over the next 10 years.

This disconnect between the demand and supply of pharmacists has yielded an increased in open positions. According to the National Association of Chain Drug Stores, the estimated number of full and part-time unfilled pharmacist positions in chain drug stores grew by 159 percent from 1998 to 2000, and the shortage is not limited to the community setting. A recent American Hospital Association survey of 715 rural and urban hospitals found that 21 percent of hospital pharmacist positions are unfilled.

As noted, the shortage affects every setting where pharmacists practice. Approximately 60 percent of pharmacists work in community pharmacies. This where patients encounter pharmacists the most and rely on most often, so the community setting is where most Americans see the effects of the shortage through longer waits, less time with the pharmacist, and service that is as good as it can be under trying circumstances.

Hospitals also face similar problems because the monitoring of hospital-based medications is extremely demanding and time-consuming, but absolutely vital. Shortages of other health professionals compound the challenges hospitals face.

Additionally, the Federal services, including the military, Veteran's Affairs, and the Public Health Service are important settings where pharmacists practice. As the lowest paying of pharmacist employers, the Federal Government has been hit hard by the shortage. Federal pharmacist vacancy rates are estimated as high as 18 percent, while the Public Health Service pharmacist vacancy rate more than doubled from 5 percent in 1996 to 11 percent in 2000. The result of these vacancies have been cutbacks in services as well as the hiring of pharmacist consultants who are significantly more expensive than uniformed or civilian pharmacists.

The pharmacist shortage is not simply a result of the greater volume of prescriptions, but also the expanded role of the pharmacist in today's health care system. The role of the pharmacist has shifted from making medications for patients to working with patients to make sure that medications work. There are numerous pressures within the system that pharmacists work through every day

and are becoming less available to answer important questions that patients have in pharmacies.

While we are proud to provide these services to our patients and cost-containment, there simply aren't enough of us to do it. Demand has outstripped supply, and the need for licensed pharmacists is considerable.

The recent introduction of H.R. 2173, the Pharmacy Education Aid Act, is an important step in addressing the pharmacist shortage. By providing financial aid to students and monies for faculty and buildings and physical facilities, the bill will ensure that pharmacist services are available to everyone by requiring participating schools to establish clinical rotations in underserved areas.

H.R. 2173 will provide further resources to rural and underserved areas by mandating the inclusion of pharmacists and pharmacist services in the National Health Service Corps.

We are extremely pleased to be here talking about this issue, and to be able to voice our support for the Pharmacy Education Aid Act. Recognizing the problem is a significant step toward the solution. Both the public and private sector have begun to take the necessary initial action to ensure that we have enough pharmacists to manage drug therapies that already have a significant impact on the health of millions of Americans, and hold so much promise for the future.

We look forward to working toward this end, and strongly encourage your continuing efforts. Thank you for listening to the views of the Nation's pharmacists.

[The prepared statement of Adele Pietrantoni follows:]

PREPARED STATEMENT OF ADELE PIETRANTONI ON BEHALF OF THE AMERICAN PHARMACEUTICAL ASSOCIATION

Good morning. Mr. Chairman and Members of the Committee, thank you for the opportunity to present the views of pharmacist caregivers in hospitals, long term care facilities, community pharmacies and other practice settings across the country. I am Adele Pietrantoni; I am a pharmacist, immediate past president and current Chair of the Massachusetts Pharmacists Association and am currently a trustee for the American Pharmaceutical Association (APhA), the national professional society of pharmacists.

I am here to speak about the acute shortage of pharmacists in the United States today. In December of 2000, in response to Congressional concern about the imbalance between the demand for and the supply of practicing pharmacists, the Health Resources and Services Administration (HRSA) released a report entitled "The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists." The report identified and quantified the degree of the current shortage.

A shortage of pharmacists is a serious problem, as pharmacists are a valuable resource for ensuring the safety, efficacy, and cost effectiveness of medication therapy for the millions of Americans who rely on medications to cure disease, resolve symptoms and maintain health. While nurses provide the most public face in the healthcare system and laboratory technicians perform vital functions to support the system, pharmacists are the patient's last line of defense to ensure the appropriate use of medications. Pharmacists work with patients to ensure that medications work—and to minimize the situations where this valuable technology causes harm.

How did this shortage emerge? The shortage stems from a hyper-demand for medications and medication therapy management services, and thus pharmacists. This demand is evident in the dramatic growth in the number of prescriptions prepared daily—growth that is sure to continue—and the significant expansion of the pharmacist's role in patient care. As the population ages, the shortage of pharmacists and other health care professionals will continue. Congress can play a valuable role in helping address this serious issue.

THE FACTS

First, let me review a few statistics:

According to the HRSA study, the number of prescriptions dispensed in ambulatory settings increased by 44% between 1990 and 1999. The number of pharmacists per 100,000 people, a standard measurement, rose 5% in that period,[1] and a study published recently in the *Journal of the American Pharmaceutical Association* estimates that this level of growth will remain the same over the next ten years.[2]

This disconnect between the demand and supply of pharmacists has yielded an increase in open positions. According to the National Association of Chain Drug Stores, the estimated number of full and part-time unfilled pharmacist positions in chain drug stores grew by 159% from 1998 to 2000.[3]

And the shortage is not limited to the community setting. A recent American Hospital Association survey of 715 rural and urban hospitals found that 21% of hospital pharmacist positions are unfilled.[4]

At a local level, we have seen a slight decline in the number of pharmacists licensed in Massachusetts from June 2000 to June 2001, while the number of prescriptions dispensed continues to rise.[5]

As noted, the shortage affects every setting where pharmacists practice. Approximately 60% of pharmacists work in community pharmacies.[6] These are the pharmacists who most patients encounter and rely on most often, so the community setting is where most Americans see the effects of the shortage through longer waits, less time with the pharmacist, and service that is as good as it can be under trying circumstances.

And similar to the community setting, drug therapy in hospitals has become an integral part of treating disease, and often the drug regimens are potentially toxic and must be very closely monitored. The monitoring of these hospital-based medications is extremely demanding and time consuming, but absolutely vital. Shortages of other health professionals compound the challenges hospitals face.

Additionally the federal services, including the military, Veteran's Affairs, and the Public Health service, are important settings where pharmacists practice. As the lowest paying of pharmacist employers, the federal government has been hit hard by the shortage. Federal pharmacist vacancy rates are estimated as high as 18%, while the Public Health Service pharmacist vacancy rate more than doubled from 5% in 1996 to 11% in 2000.[7] The result of these vacancies have been cutbacks in services as well as the hiring of pharmacist consultants who are significantly more expensive than uniformed or civilian pharmacists. A recent article in Stars and Stripes outlined the shortage problem, stating that for current pharmacy students, "working for a lower-paying VA medical center may be off the post-graduation radar."[8]

THE EXPANDED ROLE OF THE PHARMACIST

As illustrated by those statistics, the pharmacist shortage affects every state and every setting in which pharmacists work, from community pharmacies to hospitals, from long term care facilities to health maintenance organizations. The numbers, however, do not tell the whole story.

The pharmacist shortage is not simply a result of the greater volume of prescriptions, but also the expanded role of the pharmacist in today's healthcare system. The role of the pharmacist has shifted from making medications for patients to working with patients to make medications work. An asthma inhaler is not effective if the patient hasn't received sufficient training to use it correctly. Pharmacists work with patients to explain medication therapy and monitor for side effects, working in a collaborative fashion with physicians to implement, monitor, and maintain drug therapy. The myth of the pharmacist simply dispensing pills is just that, a myth. Pharmacists today are best viewed as the clinical managers of medication therapy, specialists overseeing one aspect of patient care in a similar manner to a pathologist

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[1] "The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists," Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions; December 2000, p. 4.

[2] Gershon SK, Cultice JM, Knapp KK. "How Many Pharmacists Are in Our Future? The Bureau of Health Professions Projects Supply to 2020," *JAmPharm,* Vol. 40, No. 6, p. 760.

[3] NACDS member surveys, 1998-2000.

[4] AHA Special Workforce Survey—June 5, 2001.

[5] Massachusetts Board of Registration in Pharmacy.

[6] "The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists", pg 14.

[7] Ibid., p. 30

[8] Fillmore, Randolph. "Does the Nationwide Pharmacist Shortage Threaten VA Patients' Health", The Stars and Stripes. May 21-June 3, 2001: p. 9.

or radiologist. Just as a radiologist working in collaboration with a generalist is responsible for interpreting X-rays and MRIs in the process of diagnosis and treatment, a pharmacist is likewise responsible for implementing and monitoring drug therapies in that same process.

These clinical responsibilities are essential for both patients and the profession. Such activities integrate pharmacists into the patients' overall care and allow pharmacists to provide critical advice and counseling regarding drug regimens that are complex and require rigorous compliance. However, these activities take time in what is already a very busy day, and demand expertise that cannot be addressed by automation or technicians.

Other pressures come to bear as drug therapy becomes more widespread. Pharmacists often have to manage multiple, sometimes complicated third party payer situations and health plan specific programs. Pharmacists work to manage clinically appropriate, cost-effective therapy within those programs. Adoption of a Medicare pharmacy benefit will increase the number of patients requiring assistance with third party payment systems—thus increasing the workload. A study conducted by Arthur Andersen in 1999 found that "one-fifth of pharmacy personnel time, including pharmacists, is spent on activities directly related to 3rd party issues."[9] This includes data entry, determination of eligibility status, assistance with prior authorization requirements, and response to insurance-related inquiries. Some of these tasks can—and are—delegated to personnel such as technicians, but this also diverts that personnel from medication preparation activities. Also, patients come to pharmacies today having learned about drugs through enticing but brief direct-to-consumer ads, and often rely on the pharmacist for the details of what the drugs are for and whether they are appropriate. Providing this information has become a critical, objective counterbalance, but these activities stretch the pharmacist even further.

Ultimately, while we are proud to provide these services which ensure safety, efficacy, and cost containment, there simply aren't enough of us to do it. Demand has outstripped supply, and the need for licensed pharmacists is considerable.

CONSEQUENCES OF THE SHORTAGE

The pharmacist shortage has had serious impacts on both pharmacists themselves and the services they are able to provide. Obviously, the pressure of keeping up with demand has been hard for pharmacists personally. Longer hours and less flexibility translate into stressful conditions and decreased job satisfaction. This impact is of particular concern because it prompts pharmacists to leave the profession or seek less stressful work environments.

Along with a negative impact on the pharmacists themselves, consumers suffer when pharmacists' services are limited. The shortage is forcing some pharmacies to cut back on services, and these cuts are particularly noticeable in medically underserved areas as well as in the federal services, where vacancies are more widespread. More importantly, the current work environment increases the potential for medication error. As pharmacists, we are dedicated first and foremost to the safety of our patients, but it is inevitable—as it is in any professional situation—that when we are fatigued and under pressure, the potential for mistakes increases.

Additionally, as pharmacists are drawn to higher paying jobs in industry and other sectors not involved with direct patient care, there is a real danger that faculty vacancies at schools and colleges of pharmacy will increase, restricting the capability of these institutions to increase class size and increase the supply of pharmacists. This shift away from academic institutions hinders the primary long term solution to the problem.

H.R. 2173—THE PHARMACY EDUCATION AID ACT

The recent introduction of HR 2173, the Pharmacy Education Aid Act, is an important step in addressing the pharmacist shortage, and does so in a way that will provide relief to every setting where pharmacists practice and help patients.

By providing financial aid to students, HR 2173 will trigger an immediate incentive for students who otherwise may not be able to afford this education to pursue pharmacy as a career. The bill will help schools and colleges recruit new students to study pharmacy, while the concurrent emphasis on training in rural and underserved areas will help retain these graduates as practicing pharmacists in those settings. In many of those settings, pharmacists may be the only available health care professional. Maintaining access to those professionals is essential.

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[9] Arthur Andersen LLP. (1999) *Pharmacy Activity Cost & Productivity Study,* p. 2.

By extending that aid to schools and faculty in the form of loan forgiveness and expanding existing physical facilities, HR 2173 will enhance the long-term ability of schools to expand while maintaining adequate faculty staffing. In this sense, the bill mirrors private sector efforts of some large chain pharmacies that are currently offering to pay tuition for pharmacists willing to work for them after graduation.

Additionally, the bill will ensure that pharmacist services are available to everyone by requiring participating schools to establish clinical rotations in under-served areas. HR 2173 will provide further resources to rural and under-served areas by mandating the inclusion of pharmacists and pharmacist services in the National Health Service Corps, which provides primary health services in health professional shortage areas. This measure will provide immediate assistance to those areas with especially critical needs.

The Pharmacy Education Aid Act is significant in that it addresses the fundamental problem we face—an insufficient supply to meet the demand for pharmacists. While increasing use of automation and pharmacy technicians and other changes within healthcare management systems will certainly help deal with the increasing volume of prescriptions prepared every day, the future of comprehensive drug therapy requires trained pharmacists able to provide patients with valuable clinical services. Pharmacy schools represent the only supply of these professionals, and thus must be one focus of our efforts to address the pharmacist shortage.

ON THE RIGHT TRACK

We are extremely pleased to be here talking about this issue, and to be able to voice our support for the Pharmacy Education Aid Act. The pharmacist shortage is not a temporary problem, but does not have to be a long term one. Recognizing the problem is a significant step toward the solution. Both the public and private sector have begun to take the necessary initial action to ensure that we have enough pharmacists to manage drug therapies that already have a significant impact on the health of millions of Americans, and hold so much promise for the future. We look forward to working toward this end, and strongly encourage your continuing efforts. Thank you for listening to the views of the nation's pharmacists.

Mr. BILIRAKIS. Thank you, Ms. Pietrantoni. See, I have trouble with that extra syllable.

Mr. BROWN. This comes from a guy named Bilirakis.

I don't mean to show a lack of respect.

Mr. BILIRAKIS. If my name were Brown, I think I would change it to something less common.

Dr. Roberts, please.

Mr. RUSSELL ROBERTS. That is why we two Roberts on the panel, to make it easier for you.

STATEMENT OF RUSSELL ROBERTS

Mr. RUSSELL ROBERTS. Mr. Chairman, and other members of the committee, thank you for allowing me the opportunity to address you on the labor market for health care workers. My name is Russell Roberts. I am the John M. Olin Senior Fellow at the Weidenbaum Center on Economics, Government, and Public Policy, at Washington University in St. Louis, and an Adjunct Senior Scholar with the Mercatus Center at George Mason University. As you might guess, I have a very crowded business card.

A little over 15 years ago, my mother went back to school and became a nurse. Just last month, one of her patients gave her a plaque with a poem she had written for my mother because of the care she had provided. The poem was called "Angel on the floor." My mother is one of millions of angels on the floor. They do their jobs with grace, skill and a smile under great pressure. As the Baby Boomers age, we are going to need a lot more of them, along with other health care workers.

How can we meet the health needs of Baby Boomers and all Americans while maintaining the high quality of health care we

enjoy here in the United States? Answering this question requires an understanding of how the U.S. labor market works. During the 20th Century, the U.S. workforce saw tremendous growth and tremendous change. For example, in 1900, over 40 percent of the U.S. workforce was in agriculture. Today, that number is under 3 percent.

While many occupations such as farming became less populated over the course of the 20th Century, many others grew dramatically. In 1900, there were only 438,000 teachers in America. Today, there are over 4.7 million. Other jobs are critical today that didn't even exist in 1900. Today, we have over 3 million truck drivers. Two million people work in the financial sector.

How did we find the people to fill all those jobs over the last 100 years? Who was in charge of making sure that critical professions were adequately staffed? No one. No one was in charge. Yet, our workplace and economy went through an unimaginable set of changes of that century.

How did the economy manage this transformation without supervision? Through supply and demand, the natural working of the marketplace. Our economy was able to have a sufficient number of cooks and teachers, nurses and doctors, economists and dentists, webmasters and genome researchers. No one could have predicted accurately how many people in which occupations would be necessary by such-and-such a time, but the marketplace solved the problem of staffing the needs of new industries and old ones that expanded. Employers found the workers they needed by offering a sufficiently attractive mix of pay and benefits.

Let us consider nursing, one of the occupations we are concerned with today. In 1900, there were only 12,000 professional nurses in America. My the middle of the century, there were almost 500,000. Today, there are over 2 million. How did we manage to fill that need with the skilled and caring people that we have? The same ways were used that were used in every occupation. To attract qualified employees, employers offered a package of wages and benefits sufficient to bring people into the profession.

Today, we are hearing alarming stories about current and future shortages in the health care field. If demand does indeed threaten to outstrip supply, hospitals, nursing homes and others will have to raise the pay and benefits of health care workers. Of course, they would prefer not to have to do that. Naturally, they favor government policy to make nursing more attractive than it is now and have someone else, the taxpayer, pay the bill. If Congress does not act, the shortages we are worrying about today will disappear as they have always disappeared in the past, through a mixture of higher benefits and innovations on the part of employers. If Congress intervenes, the result will be a program that benefits one group at the expense of others. The groups you have heard from today will be happy. Who will be unhappy?

Unfortunately, by artificially aiding one group of health care professionals, you may end up harming the very people you are trying to help, the patients in hospitals and in long-term nursing care. By artificially encouraging people to become nurses, pharmacists and technicians, you will have to draw them from somewhere.

What professions will not be filled as they might have been because of a subsidy program of one kind or another? What innovations will not occur because you have artificially made it difficult for other segments of our economy to find workers? Because you are increasing the supply of one type of worker, you interfere with the ability of the marketplace to cope with the inevitable challenge of dealing with the Baby Boom. The costs may be dramatic and tragic.

Imagine sitting in 1970 trying to predict the demand for telephone operators, a mere 30 years later, today. Suppose you have perfect foresight about the most critical component needed to make that prediction, the number of phone calls people are going to make in the year 2000? Well, you would predict we would need about 4 million telephone operators but, in fact, we need only about 200,000 because of the incredible advances in telecommunication technology.

There are two lessons here. The first is that it is very difficult to predict the demand for one type of worker or another. The second is that it is very difficult to anticipate the role of technology and human creativity in response to economic changes.

Imagine the mistake we would have made in 1970 if an alarm about an inadequate supply of future telephone operators we had subsidized their supply. We would have slowed the telecommunications revolution by locking us into a technology that would prove to be grossly out-of-date. That would have been unfortunate, but not nearly as tragic as making the same mistake in the health care sector.

I would suggest that no one in this room can even begin to predict how the health care market will evolve over the next 30 years. If you artificially stimulate the supply of certain segments of health care, you will have unforeseen and negative effects on other segments. No one knows where the innovations of the next 30 years will come from, and your actions may keep those innovations from happening.

Rather than artificially increasing the supply of certain favored groups, it would be more productive to remove any existing artificial barriers to supply that currently exist. Whatever action you take, I would encourage you to remember the Hippocratic oath, "First, do no harm."

In conclusion, the threat of future shortages is going to lead to greater compensation for health care workers. Who is going to pay for that—Congress, by artificial means, or the natural forces of the marketplace? People spend their own money more carefully than they spend other people's money. Government solutions: spend other people's money and lock-in existing technologies. Privately funded solutions provide the incentive for unleashing new technology and human creativity. Please, let human creativity flourish in response to the threat of shortages. Thank you very much.

[The prepared statement of Russell Roberts follows:]

PREPARED STATEMENT OF RUSSELL ROBERTS, JOHN M. OLIN SENIOR FELLOW, WEIDENBAUM CENTER ON ECONOMICS, GOVERNMENT, AND PUBLIC POLICY, WASHINGTON UNIVERSITY

Good morning, Chairman Tauzin, Chairman Bilirakis, Congressman Dingell, Congressman Brown, and members of the committee. Thank you for allowing me the

opportunity to address you on the labor market for health care professionals. My name is Russell Roberts. I am the John M. Olin Senior Fellow, Weidenbaum Center on Economics, Government, and Public Policy, Washington University in St. Louis and an Adjunct Senior Scholar with the Mercatus Center at George Mason University.

The health care workers of America are remarkable and dedicated people. A little over fifteen years ago, my mother, after raising her children, went back to school and became a nurse. Just last month, one of her patients gave her a plaque with a poem she had written for my mother because of the care she provided. The poem was called "Angel on the Floor." My mother is one of millions of men and women who are angels on the floor. They do their jobs with grace, skill and a smile under great pressure. Over the next two decades, as the baby boomers get older, we're probably going to need a lot more angels on the floor, along with other health care workers. How can we meet the health needs of baby boomers and all Americans while maintaining the high quality of health care we enjoy here in the United States?

DYNAMIC NATURE OF U.S. LABOR MARKET

Answering this question requires an understanding of how the U.S. labor market works. During the 20th century, the U.S economy added roughly one million jobs a year. But more impressive than the increase in the number of jobs has been the change in the composition of jobs over the last century. In 1900, over 40% of the U.S workforce was in agriculture. Today that number is under 3%.

Think about the magnitude of that transition. If the proportions had stayed the same, we'd have over 50 million workers in the farm sector instead of the 3 million we have today. Somehow, the economy provided opportunities for those workers who were no longer needed on the farm.

After agricultural workers, the next most common occupation in 1900 was "servant." Working in the mining industry was one of the top ten occupations in 1900. Dressmakers, tailors, blacksmiths and shoemakers were all among the top twenty occupations. Today, all of those occupations have dwindled dramatically as a proportion of the workforce for the same reason that agriculture is less important as a source of employment: the unforeseen explosion in technology, human creativity and wealth that transformed our lives in the 20th century.

While many occupations became much less populated over the course of the 20th century, many others grew dramatically. In 1900, there were only 438,000 teachers in America. Today, there are over 4.7 million. We went from 117,000 cooks in 1900 to over 2 million today. Other jobs are critical today that didn't exist in 1900. Today we have over 3 million truck drivers. The financial sector employs over 2 million people.

How did we find the people to fill all those jobs over the last 100 years? Who was in charge of making sure that critical professions were adequately staffed? No one was in charge. And yet our workplace and economy went through an unimaginable set of changes over that time period. How did the economy manage this transformation without supervision?

Through supply and demand, the natural working of the marketplace, our economy was able to have a sufficient number of cooks and teachers, nurses and doctors, economists and dentists, webmasters and genome researchers. No one could have predicted how many people in which occupations would be necessary by such-and-such a time. But the marketplace solved the problem of staffing the needs of new industries and old ones that expanded. Employers found the workers they needed by offering a sufficiently attractive mix of pay and benefits.

Nursing, one of the occupations we're concerned with today, has an interesting and informative history. In 1900, there were only 12,000 professional nurses in America. By mid-century, as the health care industry began to evolve, there were almost 500,000. How did those jobs get created? How did we manage to get women and men to fill those jobs? Today, there are over 2 million nurses, over a four-fold increase since 1950. How did we manage to fill that need with the skilled and caring people in the nursing profession? The same ways were used that were used in every occupation. To attract qualified employees, employers offered a package of wages and benefits sufficient to bring people into the nursing profession.

The labor market does not work in a vacuum. Here in the United States the government has intervened in the labor market in many ways, direct and indirect to affect the attractiveness of work and the attractiveness of one industry over another. But the role of the government has been less dramatic than it has been in other countries. A comparison with Europe over the last 30 years is instructive. Over the last 30 years, European governments have been much more involved in

tinkering with labor markets relative to the US experience. European labor markets are more highly regulated. The result has been that Europe faces much higher unemployment rates and much slower job growth than the United States over the same period.

THE MARKET FOR HEALTH CARE PROFESSIONALS

Looking more specifically at the health care market, the coming years will bring many changes as the baby boom population changes. The existence of the baby boom is well known by many. But no one knows precisely how the aging of the baby boomers will affect the demand for various professions in and out of health care. The reason such impacts are impossible to quantify precisely is because it is impossible to predict how technology and human creativity will respond to the demographic phenomenon known as the baby boom.

Today we are hearing alarming stories about current and future shortages in the health care field. If demand does indeed threaten to outstrip supply, hospitals, nursing homes and others will have to raise the pay and benefits of health care workers. Of course, they would prefer not to have to pay higher wages. Naturally, they favor government policy to make nursing more attractive than it is now and have someone else, the taxpayer, foot the bill. If Congress does not act, the shortages we are worrying about today will disappear as they have always disappeared in the past-through a mixture of higher benefits and innovations on the part of employers.

But suppose Congress cannot resist the temptation to intervene. The result will be a program that benefits one group at the expense of other groups. The groups you have heard from today will be happy. Who will be unhappy?

Unfortunately, by artificially aiding one group of health care professionals over another, you may end up harming the very people you are trying to help, the patients in hospitals and in long-term nursing care. By artificially encouraging people to become nurses, pharmacists and technicians, you will have to draw them from somewhere. What professions will not be filled as they might have been because of a subsidy program of one kind or another? What innovations will not occur because you have artificially made it difficult for other segments of our economy to find workers? Because you are increasing the supply of one type of worker, you interfere with the ability of the marketplace to cope with the inevitable challenge of dealing with the baby boom. The costs may be dramatic and tragic.

Imagine sitting in 1900 and worrying about the supply of telegraph operators over the next 70 years. Even if you had perfect knowledge of how the U.S. population would grow, you would have done a terrible job predicting the demand for telegraph operators because you would have been unable to predict the evolution of the telephone and its role in our lives. In 1900, telegraph operators and messengers outnumbered telephone operators by almost ten to one. But by 1970, telephone operators had increased 20-fold and dwarfed the number of workers in the telegraph industry by many times.

Now imagine sitting in 1970 and trying to predict the demand for telephone operators by the year 2000. Suppose you have perfect foresight about the most critical component needed to make that forecast, the number of phone calls people make. Based on the number of calls made in 2000, you would predict a need for four million telephone operators. In fact, the need is only around 200,000 because of incredible advances in technology.

There are two lessons here. The first is that it is very difficult to predict the demand for one type of worker or another. The second is that it is very difficult to anticipate the role of technology and human creativity in response to economic changes.

Imagine the mistake we would have made in 1970 if in alarm about an inadequate supply of future telephone operators we had subsidized their supply. We would have slowed the telecommunications revolution by locking us into a technology that would prove to be grossly out of date. That would have been unfortunate, but not nearly as tragic as making the same mistake in health care. I would suggest that no one in this room can even begin to predict how the health care market will evolve over the next 30 years. If you artificially stimulate the supply of certain segments of health care, you will have unforeseen and negative effects on other segments. No one knows where the innovations of the next 30 years will come from.

IS THERE NOTHING TO BE DONE?

Is there nothing Congress can do to deal with the challenges in the health care labor market that are before us? There is the potential for constructive action. Rather than artificially increasing the supply of certain favored groups, it would be productive to remove any existing artificial barriers to supply that currently exist. One

example would be the burden of paperwork that reduces the joy and on-the-job satisfaction of health care workers. We hear a constant cry that the healthcare workplace is too devoted to filling out forms rather than caring for patients. Surely there is room for improvement here. But whatever action Congress takes, I would encourage you to remember the Hippocratic oath: first, do no harm.

Thank you very much.

Mr. BILIRAKIS. Thank you, Dr. Roberts. I should know and I did know, but I don't recall, when the National Health Service Corps was created, but that was created to cover shortages among medical practitioners in rural areas, et cetera, areas where they were needed and they weren't available. Do you have a problem with that program?

Mr. RUSSELL ROBERTS. Oh, the government has done a lot of things that has expanded the supply of workers in different areas, and it is done at all different levels, the Federal one being the obvious one, but the State level is very dramatic in the form of subsidizing education.

In general, when the Federal Government intervenes, it is going to do it in a very blunt way. It is not going to be generally. You can focus support. I mean, generally is going to have trouble dealing with some of the regional problems that we have heard about today in the nursing shortages. So, I think the general rule is to make sure that you allow the maximum flexibility in any program that you design.

Mr. BILIRAKIS. I am not sure how to translate that. Ms. O'Leary, nurses are covered, are included in the National Health Service Corps. Do you have any of those nurses in your hospital?

Ms. O'LEARY. No, we do not.

Mr. BILIRAKIS. Why?

Ms. O'LEARY. Because we are not allowed to employ them.

Mr. BILIRAKIS. Because there is no shortage of health professionals in that area, is that why?

Ms. O'LEARY. No.

Mr. BILIRAKIS. Why?

Ms. O'LEARY. My understanding is that they are not allowed to work at our facilities to pay off their loans.

Mr. BILIRAKIS. In your facility, or in your facilities?

Ms. O'LEARY. I can speak for my own facility.

Mr. BILIRAKIS. Well, there must be a reason why they are not allowed to work there.

Ms. O'LEARY. I would be happy to check that out for you and get back to you.

Mr. BILIRAKIS. Do you know, Ms. Heinrich?

Ms. HEINRICH. The people in the Corps have to work in a designated shortage area, and my guess is that the facility in the area is not designated as such.

Mr. BILIRAKIS. Well, that is what I thought was the answer, but what we are talking about is not a shortage of medical doctors in that area. God knows, there are plenty of medical doctors in that area, but there is a shortage of nurses. So, are we saying that the fact that there is no shortage of medical doctors also applies to the nursing profession?

Ms. HEINRICH. The way that the shortage areas are designated is for primary care providers, and at this point the way they count,

they only count physicians. They don't take into account the other providers.

Mr. BILIRAKIS. That is what I am getting at.

Ms. HEINRICH. But the other point here that I have been trying to make, and maybe others have, too, is there is so much geographic variability about how many people are willing, interested in taking positions in particular facilities, and it isn't just actual numbers of people available. I think it is really important for us to remember that the actual number of nurses is continually increasing, it is not decreasing. The rate of growth has slowed down, that is for sure, but at this particular point in time you will have different facilities say that they have openings, but the other part of that is that not so many years ago some of those same facilities were laying nurses off.

Mr. BILIRAKIS. What I am getting at is, what some of the legislation would do, and that is include MTs insofar as the National Health Service Corps is concerned, and obviously maybe pharmacists. We would have to look into that, but I guess if it isn't working where nurses are included, then it isn't going to work any better for medical technologists and pharmacists. Dr. Roberts, I am not saying that is going to be the decision—but, first, we have to cross that particular bridge, as I see it, and then possibly consider whether the other shortages should be included.

Ms. HEINRICH. If I could make one comment, the nurses that are included now in the Corps are nurse-practitioners, so they usually have more advanced training. They are considered primary care providers.

The nurses with the experiences that people in acute care facilities are looking for have a different skill mix, and so we are not talking about the same population of nurses.

Mr. BILIRAKIS. So they are not included then in the Service Corps.

Ms. HEINRICH. RNs, general RNs are not included.

Mr. BILIRAKIS. That is good to know. And I ask questions about the aides and poor salaries and ask you what the nurses' salaries are these days, but the red light is on. Possibly someone else will get to that. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Six and a half years ago, we had something that we referred to around here as the "Gingrich revolution", where most of the people in the class of 1994 that were elected to Congress talked a lot like you do, Dr. Roberts, and fortunately for the country, most of them got over it.

I was just—I hear you talk about the market taking care of everything. How is the market doing in prescription drugs in this country, and keeping prices competitive, and getting prescription drugs available to people that don't have access? Tell me about that a little bit.

Mr. RUSSELL ROBERTS. I will agree with you, Congressman Brown, that economists do have a tough time running for Congress and being successfully elected. There are a couple, but it is a tough haul with our world view.

The pharmaceutical industry is a rather mixed picture, I would think. We have the most innovative pharmaceutical industry in the world. We have contributed through that industry to the world's

health, again, in unimaginable ways. If you had sat in 1900 and looked at the probability of dying in childbirth, the probability of dying from various diseases, our ability to intervene and make people's health better, it is a pretty dreary picture compared to now.

As a result, over the last 100 years we have had extraordinary, again unimagined, unforeseen innovations that have transformed our lives. Everybody in this room probably has someone or knows someone who has benefited from that industry's innovation.

Now, how they price it, of course, they want to make a profit, that is the way our system works and that is what spurs that innovation. Could they do a better job of serving some of the population? Sure, they could. Can you help them do that? Probably. But I certainly don't think you would want to intervene with their incentives to innovate. Certainly wouldn't want to have 1950's drugs at 1950's prices, rather have 2001 drugs at 2001 prices. I think most Americans would prefer that.

Mr. BROWN. It would be nice to have those drugs—you know, it is an industry—without belaboring the point—it is an industry that is the most profitable in America. They get the protection of government patents, they get all kinds of research subsidies from the government, and they reward American taxpayers by charging us two and three times more what they charge in other countries, but that is a whole other issue.

Let me shift to the real issue at hand. Ms. Baker, from Newton Falls, and testifying on behalf of the American Nurses Association about the shortage, all of us are troubled by that shortage, and we hear more and more about it, and we are especially thankful to the Nurses Association, the ANA, and to Ms. Capps for continuing to put that issue in front of this Congress.

Share some of the specific problems that you have seen at the Cleveland Clinic and elsewhere, and talk in some detail—you kind of went over it fairly quickly because of time constraints—the causes of dissatisfaction among nurses.

Ms. BAKER. I can speak to some of the problems that I have seen both at the Cleveland Clinic Foundation and elsewhere in my career. The one that comes to mind first and foremost is something that I think affects the person that we really need to think about here and that is the patient, and that is bed availability. We have had to close beds for the simple fact that we don't have the nurses to give the adequate care and the quality of care that we would like to give.

The dissatisfaction, I think, comes from the lack of staffing, especially recently with the shortage we are facing, and that is definitely going to get worse before it gets better. Would I encourage someone to go into nursing? Absolutely. It is a very rewarding, wonderful career, and it is very exciting, but we need to get that out to the younger folks in the high schools.

Mr. BROWN. Talk a little bit more about the dissatisfaction, some of the specific things that you see, that fellow nurses talk to you about in terms of their retiring early, or moving into other jobs, or moving into less stressful, maybe corporate environment, rather than an inner city hospital. Talk about that a little bit.

Ms. BAKER. Personally, I can't speak to that. I can speak to things that I have heard. I don't have a lot of experience with that.

I think a lot of dissatisfaction comes from salaries. A lot of nurses don't feel that they are paid what they are worth, which I am sure that comes with many different professions, and the biggest dissatisfaction right now is the inadequate staffing.

Mr. BROWN. Thank you. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you, Mr. Brown. Mr. Burr, to inquire.

Mr. BURR. Thank you, Mr. Chairman. It was awfully kind of Mr. Brown to point out the class of 1994 since I am the only person from that class. Let me assure him and everybody here that I haven't forgotten why I came. I came here because I saw an institution that never cured anything. They tried to treat it, but they never fixed it. And I think that we have an unusual opportunity to fix some things. Mr. Roberts, I appreciate your comments. I think it is important that when we talk about a real cure for something, when we talk about solving it so that it is beneficial to everybody, I think that it is important to put everything on the table, and part of the reason that we never get there is we make off-limits certain things before we start the debate, or before we look for the options.

You all have done a very good job of highlighting what I think are the shortages that exist, whether it is in nursing, whether it is in pharmacy, whether it is in technicians. I think that everybody has migrated to low pay and demanding work schedule and situations that might present themselves in the field.

Members of Congress have introduced specific legislation that addresses specific things that I believe do show some promise to recruitment. It may show some promise to retention. But I believe that as long as there is a question as to whether we have solved the problem, that we have got to understand that there is more that we have to do as a Congress, if we truly want to fix the problem.

We have a system called Medicare that sets arbitrary reimbursement rates. Those rates are adopted by every other health entity within the marketplace, and those are the rates that require every person in the health care field to adjust their reimbursement to employees based upon the reimbursement for services provided. There is no way to solve the overall problem if, in fact, we are not willing, if Congress does not have the guts to, for once, take the Medicare system and modernize it and, at the same time, allow a system to be instituted that takes into account not just what we are willing to reimburse for service, but what the cost of all the entities that goes into providing that service can be. If we are still in a marketplace 2 years from now where we have urban markets that compete for nurses between urban and rural, what we have is smaller hospitals with less variation in their bottom line that, in many cases, make a midyear adjustment because there was an urban shortage, and when the hospitals there raise their pay a dollar an hour, they drain that rural market 30 miles away where everybody ran for the higher pay. I can't blame those nurses.

The problem is, how long can that hospital continue to exist there when in some cases they take a $.5 to $1 million adjustment to their operating budget halfway through a year? It is impossible. It cannot last forever. And what we have is a real opportunity to solve short-term, I think, the recruitment problem. Ms. Capps has

contributed to that. I think Mr. McGovern, as it relates to pharmacy issues and others, and I think this is a very promising thing, to see colleagues engaged to this degree, but this will only be short-term unless we show the will to fix the entire system.

GAO reported several years ago—I can't remember—that we had a glut of pharmacists. Today, I think most would agree we have selective shortages of pharmacists. Were you wrong then, or has something happened?

Ms. HEINRICH. We have heard today that there has been a dramatic role expansion of pharmacists. Pharmacists are being used in a variety of ways, in acute care hospitals and in the community. Certainly, what has happened with managed prescription drug programs—someone said increased demand—what I think is interesting here is that it is very hard to predict forward what the demand is going to be because of a potential for new technologies.

We have also heard today that there are major shortages of medical technologists. I think in that instance it is a question of bright, young people deciding to go in other directions.

When we looked at nursing—again, if you look at 1994 and 1995, hospitals in fact were laying nurses off, and now in 1998, 1999, 2000, you see the demand dramatically increasing, and I think that, as you say, the environment is very unstable, and it is very hard to predict what the future health care system——

Mr. BURR. The environment has contributed greatly to these decisions. I would go back to, I think, a statement that Mr. Bilirakis made. One of the questions we need to determine is if the calculations you used to determine disadvantaged or shortage areas are correct, when the only gauge used is physicians. It is very realistic to believe that I could point to ten areas of my district where I can show you sufficient physicians that wouldn't meet the test of shortage, but a nursing shortage that really has a quality of care issue tied to it because either wages are affected in that overall market, or they have to turn to shutting downwards, which affects the service that they can provide to the community.

I think that it is interesting that the Federal Government has never recognized pharmacists as a Medicare-approved health care professional. I know my time has run out, Mr. Chairman. I hope all of you understand there are more questions that we have to ask. There are more answers that we have to find if, in fact, we don't want to have this exercise on a regular basis, and the difference would be that the individuals at the table might be representing a different slice of the health care professional field.

Mr. BILIRAKIS. The gentleman's time has long expired.

Mr. BURR. My hope, Mr. Chairman, is that you have started something extremely good.

Mr. BILIRAKIS. Well, I would hope that all members of the panel, and the previous panel, particularly this panel, though, would consider Dr. Roberts' points. We could put out a fire, but that doesn't necessarily mean that the problem is solved over the long-haul. We have got to take all that into consideration. Ms. Capps, to inquire.

Ms. CAPPS. Thank you, Mr. Chairman. I want to thank all of you who testified today. It was instructive, and I am glad I could be here. Those of you who spoke from your profession's experience at

the front line, so to speak, I particularly appreciate your being part of our probing this issue of shortages in various areas.

I do want to address, Ms. O'Leary, something you referenced, and the chairman brought it up as well. I appreciate your comments about the Nurse Reinvestment Act. I am just going to clarify and hope that I can move on to questions for someone else. But you were correct in stating that the proposals in the Nurse Reinvestment Act regarding the Nurse Corps centers only around non-profit or public institutions, and this decision is in the bill, as it presently states, was based on past Service Corps practice. And we are in conversation with the Federation of Health Care Systems on this matter, and will continue to do that. I just wanted to get that out there so that that is said.

I do want to direct my concerns and questions to you, Dr. Russell Roberts, because your testimony—we were just advised to pay attention to it, and I am concerned that aspects of it will dissuade some from our role here because you made comments like there is really no one in charge of staffing critical professions, and I would beg to differ. That is how I see our role as not being in charge, but being very interested in certain vital professions that my family members or I can be confident when I go into a hospital, that I will get the care. And I hate the fact that nurses have told me that they wouldn't want their relatives to be patients in the hospitals where they worked. The shortages are that personal to them.

And you were comparing my profession and others, with competition for telegraph operators and others, and I get the feeling that the free market works with health care professions like it does with toothpaste and, you know, which brand of car you are going to buy.

I think there is a piece that is different about some professions, and I would maybe equate nurses with educators, teachers, and think a little bit about the subsidies that we give to higher education institutions because we feel that that is the kind of investment we need to make for the future. That is talking about the future. But we also need to make sure that there is safety and quality care for those who are in need of health, of remediation of whatever kind.

And you mentioned that if we interfere—and then I will let you respond—that if we interfere with the market, that—because we can't really predict and so forth—we will be draining the market from other areas and pulling people into nursing, and then there will be shortages in other areas, so that we are kind of messing with the system. But I have to tell you how it feels to be going—and my bill directly deals with the whole range of nursing, including certified nurse assistants because long-term health care is a critical issue. It is not as much on the table today, but we are going to get there in this bill, too, but to sit in a nursing home with the staff there in my district and have them tell me that the biggest competition is McDonald's, and that is the place where we are for a lot of our health care workers in this country right now.

So, I just want to get back to saying that—just a question, if you would respond—if we trust the market to address the shortages, how do you anticipate—how is the market going to know? It takes a while to become educated, to become a nurse. If today there is a shortage at a particular hospital—Ms. O'Leary's hospital, Ms.

Baker's facility—you can't just open the door and have all these people walk in. How would you deal with that, the time gap?

Mr. RUSSELL ROBERTS. I just want to say the reason—and I appreciate your concerns—the reason I especially appreciate your passion for the importance of health care in all of our lives, and people like my mom and other practitioners here who I have tremendous respect for—the reason I mentioned telephone operators is not to suggest that nurses are like toothpaste or cereal or other goods that we buy and sell in the marketplace. There is something important we can learn from the telephone example, which is that in cases where technology is advancing very rapidly, it is very hard to anticipate what is going to happen and how the market is going to evolve and how the needs for various parts of the market are going to evolve.

Any solution—the solutions that you would favor or that other people might favor—are going to rely on incentives. It doesn't deny that there are emotional, deep, spiritual satisfactions people get from their jobs, but we are all going to be using either through the marketplace or government programs, various carrots and sticks to motivate people to pull them into professions that we might think are more important. So that is what I think is the important lesson.

Now, it may be true that right now that McDonald's or other opportunities much wider than McDonald's are the things that are pulling people away from nursing, but if we subsidize nursing enough we will start pulling them away from pharmaceutical research, from chemistry, from other professions that are mentioned here today, the professions we haven't mentioned today that are part of the caring professions that motivate people, the teachers and others, and I think that is the risk. The risk is that if we artificially stimulate one sector of the health care market, we are going to draw people in. That is what we will see. That will be the seen impact. What will be unseen are the things that don't get developed as a result of those subsidies. You will never see those. Those people will never be sitting here at this hearing table to complain because they won't come into existence. You will have forced those industries to deal with those shortages in a different way than the ones we are talking about today where there are actual people here to complain about them, but that is the risk. And I think you just should proceed extremely cautiously.

Ms. CAPPS. I know the red light is on, but if I could just question whether you really do perceive this as an artificial shortage?

Mr. RUSSELL ROBERTS. I am sorry, maybe I misspoke. It is not an artificial shortage. I don't know whether it is a shortage or not. The Congressional Research Service, in their recent study, says it cannot be stated conclusively based upon available labor market indicators that there is an across-the-board shortage of RNs at the present time. I am sure that if nothing else changed and we all got older—I am a Baby Boomer, and as I get older and my cohort, there is going to be a need for more nurses and other types of health care professionals, there is no doubt about that. I am just suggesting that problem will be solved and that most of the things that you will do will artificially induce people to become nurses. The marketplace will do it naturally, if you leave it alone.

Mr. BILIRAKIS. Did you have anything further, Mr. Brown?

Mr. BROWN. That is it, Mr. Chairman.

Mr. BILIRAKIS. Ms. Capps, anything further—probably an awful lot further, but——

Ms. CAPPS. Do we have anymore time?

Mr. BILIRAKIS. The Chair will yield, without objection, another couple of minutes to you, if you have something.

Ms. CAPPS. You are doing this because I am a nurse, aren't you?

Mr. BROWN. Also because you know more about this than anybody else.

Ms. CAPPS. I wanted to focus—I didn't want to dwell, put Dr. Roberts on the spot the whole time—and I appreciate, Ms. Baker, there is talk that the new technology in health care field means that we need to be so flexible in how we train nurses. It is sort of like—I guess when Dr. Roberts was talking, I was thinking, well, maybe 1 day there will be a robot that can do all the things that you do so well.

You have seen changes—others can respond, too. We have all seen changes in how we deliver care. Do you think there will be the time when there is a need for fewer caregivers?

Ms. BAKER. Personally, no, I don't see that time coming. i think as the population ages, with the newer technology, people are living longer, there is going to be a greater need for nurses as well as other health care givers.

Ms. CAPPS. Thank you. And maybe to share this a little bit, what about—we have heard statements like those that are in hospitals now have more acuity. Tell us, Ms. O'Leary, what does that mean?

Ms. O'LEARY. Patients are much sicker than they were when I first came out of school, and because of that we are going to be requiring more and more RNs to take care of those folks. The work is much different. The skill set is much more advanced than when I came out of school. It requires critical thinking skills, the ability to manage very high technology. It is a different job than when we came out of school, and it requires a different person in those shoes. So, I agree with you, I think that the demand for health care workers is going to increase.

Mr. BILIRAKIS. We have got to cut it off somewhere, I guess.

Ms. CAPPS. Right. You have the last word.

Mr. BILIRAKIS. What is the role of government? One of you made that comment. I kind of say that to myself all the time, in trying to make my decisions up here, and there is a role. There is a role up to a certain point, and I think it is important, by holding this hearing and that we do the best that we possibly can up here. But I think it is also important that we know that you do the best that you can, and maybe that is Dr. Roberts' point, I don't know. I made the comment earlier about the beginning salary for pharmacists right out of school, in Florida in any case, $70- to $90,000 a year salary. My God. It blows my mind. But there is a need there, there is a shortage, and they are reaching out for that need. Is the same thing happening in the other professions? And I think it is just important that they sort of look in the mirror in that regard.

Ms. CAPPS. No, it isn't.

Mr. BILIRAKIS. No, it isn't. That may be part of the answer. Part of the answer is what we can do up here, but part of the answer

is—Pasco-Hernando Community College, for instance, down there, has a nursing program. I understand that they are not turning out very many nurses, which means apparently not many of the young people are going into it, is that correct?

Ms. O'LEARY. That is true.

Mr. BILIRAKIS. And you probably heard me talk about St. Petersburg College, now a 4-year program, again, to try to meet that need as well as the teachers need. But somehow—and you made a comment that you were trying to recruit and press upon the significance and that sort of thing—but somehow we can do everything we possibly can, but if we can't get them there, then we are not meeting the need.

Ms. O'LEARY. Or if there isn't space for them to attend school.

Mr. BILIRAKIS. I am on the Veterans Committee, and I have always had a great big interest in that regard, and I know that an entire bays, entire floors of veterans facilities are shut down because of a shortage of personnel, nurses, et cetera. So, the shortage, I think, is there, there is no question about that, but we all have to try to do the best we can to meet that need, not just look to Congress—and I am not suggesting that that is the case here—but we can't just look to Congress to sort of solve it all.

Well, please take advantage of the fact that there is great interest. We want to try to come up with help. Feel free to submit to us any advice that you may have, any ideas that you may have you think should be the role of the Congress or should be the role of the government, and also, of course, I like to think that you would be willing to respond to any written questions that we will have of you to help us do our job up here.

Mr. Brown, anything further?

Mr. BROWN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you very much, I appreciate, we all appreciate your taking the time to be here. It is going to help. The hearing is adjourned.

[Whereupon, at 2:05 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF HON. JAMES P. MCGOVERN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS AND HON. MICHAEL K. SIMPSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IDAHO

Mr. Chairman, Ranking Member Brown and Members of the Health Subcommittee, thank you for holding this important hearing on safety net public health programs. We appreciate the opportunity to present our views on this issue.

We believe the shortage of trained healthcare workers in the United States is a looming crisis in our healthcare system. We consistently hear from our constituents that there simply aren't enough medical professionals to serve patients, and we believe this shortage could have serious implications for the future quality of our healthcare system. The federal government must act to address this crisis before it's too late.

We welcome the efforts of our colleagues to address the shortage of nurses, laboratory technicians and other professionals. We recently joined together to address the shortage of pharmacists in the United States. We have heard from constituents, from hospitals, from independent pharmacies, and from pharmacists themselves about the shortage of pharmacists in the workforce. We have learned that there are not enough pharmacists who are willing to enter the practice of pharmacy. We have seen pharmacists who are overworked because positions at pharmacies continue to stay vacant. We have met with pharmacy students who tell us they will not enter the practice of pharmacy because they can make more money in research or areas other than the retail setting where they are most needed.

There is a common misconception that pharmacists only count the pills prescribed by doctors. However, pharmacists are the third largest healthcare professional group in the United States, behind doctors and nurses. In many cases, the pharmacist is the last contact between a trained medical professional and the patient.

In March 2000, the Institute of Medicine (IOM) released its landmark report "To Err Is Human." This report focused on medical errors among all medical professionals, including pharmacists. In the report, IOM investigators noted that pharmacists cited the following factors that led to mistakes-too many phone calls (62%), unusually busy day (59%), too many customers (53%), lack of concentration (41%), and staff shortage (32%). All of these concerns can be addressed by hiring more pharmacists.

In December 1999, Congress requested that the Department of Health and Human Services (HHS) study the extent of the pharmacist shortage. "The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists" was released in December 2000 by the Secretary of HHS. This report documented the critical role that pharmacists play in our health delivery system and found that there is indeed a shortage of these key health providers that is growing increasingly worse. This report concluded "there has been an unprecedented demand for pharmacists and for pharmaceutical care services, which has not been met by the currently available supply."

While we know there are steps that can be taken by the pharmacy community, we believe the time has come for Congress to act. As a result, we have introduced H.R. 2173, *the Pharmacy Education Aid Act of 2001.* Our bill addresses the current shortage of pharmacists in the U.S. by providing financial aid to students, faculty and schools of pharmacy.

Our legislation provides scholarships and loan forgiveness to students if they enter the practice of pharmacy. It requires most students to repay the Federal government by practicing or teaching pharmacy where they are most needed, such as medically underserved areas and hospitals. Under our bill, funds are made available to schools of pharmacy to attract teachers through a loan repayment program, to improve their information technology systems and to upgrade their physical teaching facilities. In exchange, schools will send the majority of their pharmacy students through at least one advanced practice/clinical rotation at a safety net provider. By training students in this manner, a school will become a "qualifying school of pharmacy" and will be eligible for funding under the Pharmacy Education Aid Act.

We believe this imminent crisis must be addressed at the source-recruitment and retention of new pharmacists. For this, we need to recruit new students to colleges and universities; we need to ensure that enough faculty exist to teach these new students; and we need to ensure that there is an incentive for graduates to practice pharmacy where they are most needed. These are goals that can and must be advanced both by private industry and by Congress.

By increasing the number of pharmacists, Congress will be addressing a number of issues at once. First, more pharmacists in the workforce will reduce the number of medication errors. As the last line of defense between the patient and the medical world, pharmacists can identify dosage errors and potential problems with drug interactions. However, it is more difficult for a pharmacist to prevent these errors if they are overworked because the pharmacy is understaffed. Second, our pharmacy community will be under more pressure as the country continues to move from an in-patient healthcare delivery system to an outpatient, prescription drug-based system. Our society is aging and becoming more reliant on prescription drugs. Pharmacists are becoming increasingly important actors in the healthcare delivery system as we become more dependent on prescription drugs—especially if and when Congress provides a Medicare prescription drug benefit. Third, there are 43 million uninsured people in the United States today. Pharmacists provide what is called "Medication Therapy Management Services"—in short, pharmacists provide advice both to the insured and the uninsured. The role of the pharmacist in relation to the uninsured is mostly in an over-the-counter capacity. It is clear that pharmacists will continue to play an important role in providing healthcare services for the 43 million uninsured, regardless of how Congress or the private market ultimately addresses this problem.

Among the witnesses testifying before you today is Dr. Adele Pietrantoni. She will testify about the importance of pharmacists in the healthcare delivery system and about the shortage of pharmacists in the U.S. We hope she will provide insight to this critical shortage and will be a resource to the Committee as it addresses the shortage of trained healthcare professionals.

Thank you for this opportunity to express our concern with the shortage of pharmacists and other healthcare professionals. We commend the Committee for holding this hearing and we look forward to working with you on this critical Issue.

PREPARED STATEMENT OF NATIONAL ASSOCIATION OF CHAIN DRUG STORES

Mr. Chairman and Members of the Subcommittee. NACDS appreciates the opportunity to submit this statement for the record regarding the critical shortage of licensed pharmacists in the United States. The shortage of pharmacists is having an impact on the ability of your constituents and our customers to have ready access to pharmacy services in many areas of the United States. In many rural areas, pharmacists are often times the only accessible health care professional, and in many communities, pharmacists are available 24 hours a day, 7-days a week. The pharmacist shortage threatens the very fabric of this important primary health care system.

The Institute of Medicine's (IOM) 2000 report "*To Err is Human: Building a Safer Health System*" demands improvement in patient care. The IOM report confirms the idea that improper use of prescription medication jeopardizes patient safety. Pharmacists are professionals with specialized training and understanding of medication therapy, disease state management and drug administration. In many cases, pharmacists are the only health care professionals with which patients come in contact. The only way to avoid expansion of the problems highlighted in the IOM report is to ensure an adequate supply of pharmacists in all health care settings.

PHARMACIST SHORTAGE CREATES ACCESS PROBLEMS FOR AMERICANS

A December 2000, the U.S. Health Resources and Services Administration (HRSA) reported to Congress that the "evidence clearly indicates the emergence of a shortage of pharmacists over the past two years." [1] The report went on to say:

> "This shortage is considered a dynamic shortage since it appears to be due to a rapid increase in the demand for pharmacists coupled with a constrained ability to increase the supply of pharmacists. *The factors causing the current shortage are of a nature not likely to abate in the near future without fundamental changes in pharmacy practice and education."* (Italics added.)

The study found various reasons for the pharmacist shortage, including:

- **Prescription Medication Use Has Increased:** An increase in the use of prescription medications by consumers, especially older Americans, requires that more pharmacists be available to provide these prescriptions. As policymakers consider the inclusion of a pharmacy benefit in Medicare, the need for pharmacists will only increase.
- **Prescription Insurance Coverage Has Increased:** An increase in private, third-party prescription insurance coverage has helped to make prescription medication more affordable for more Americans. However, it has also required that pharmacists spend more time involved with paperwork and administrative tasks (e.g. verifying insurance coverage) and coverage issues (e.g. drug formulary management) relating to filling the prescription, rather than spending time on patient care activities.
- **Pharmacist Workforce Has Changed:** More and more females are choosing pharmacy as a career. Evidence suggests that, for family and other reasons, female pharmacists work fewer hours than their male counterparts. Thus, the increase in the female pharmacist workforce has resulted in the need for more pharmacists.
- **Pharmacist Educational Requirements Have Changed and Increased:** Most pharmacy schools require that the pharmacist complete the Doctor of Pharmacy (Pharm.D.) degree as the "entry level" degree to practice pharmacy. Training for this professional program is longer than the traditional B.S. pharmacy program. As a result of lengthening education requirements, some schools did not graduate any pharmacists in a given year, while others have not received additional funds to accommodate these new educational requirements, resulting in a reduction in overall class size.
- **Pharmacist Practice Responsibilities Have Changed:** Pharmacists and pharmacies are increasing the level and type of patient-related prescription services they provide, and assuming greater responsibilities in assuring quality in drug therapy and prevention of medication errors. These services, which are in greater demand because of the increased use of prescription drugs, help to assure that patients obtain the maximum benefit from medication use, and include case and disease management, step therapy protocols, refill reminders, and patient counseling.

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[1] "*The Pharmacist Workforce: A Study of the Supply and Demand for Pharmacists*," Health Resources and Services Administration, Bureau of Health Professions, December 2000.

The HRSA study also projects a 20 percent increase in the number of retail prescriptions filled to 4 billion by 2004, a number that will certainly increase if a Medicare prescription drug benefit is enacted.

IMPACT OF THE PHARMACIST SHORTAGE IN COMMUNITIES

The shortage of pharmacists has reached communities across the country, and many patients and pharmacy patrons are feeling the effects. Many pharmacies are unable to meet the demands of the public, and can often end up closing stores for several hours because they cannot staff them. The pharmacist' shortage has captured the attention of many newspapers, and here is just a sample of the articles that we have identified from various communities around the country:

"*The fact is that there are 10,000 fewer pharmacies nationwide than there were in 1990, and this puts more stress on the stores that are still around . . .*" "Where are drugstores going? More are closing while the demand rises in North Carolina", **The News & Observer, Raleigh, NC, Thursday, May 31, 2001.**

"*Hardly a day goes by that we don't get someone with a handful of bottles asking for refills . . . they are saying they are sick of the backup of service and of not knowing when the pharmacy is going to be open*", **The Hartford Courant, Tuesday, July 3, 2001.**

"*Filling vacancies at hospitals, clinics and nursing homes, already difficult in a strong economy, will only become harder as Northeastern Minnesota's population grows older . . .*"

"*The combination of more people and more drugstores is making it harder to fill vacancies for pharmacists on the Coast and in other parts of Mississippi.*", "Pharmacists in Demand Coast Growth Seen as Factor in Crunch", **Sun Herald,** p.F1, Wednesday, September 20, 2000.

Headline: "PHARMACY SCHOOLS STRUGGLE TO FILL THEIR CLASSES: DEMANDS ON THE PROFESSION INCREASE, PROGRAMS BECOME MORE RIGOROUS, AND APPLICATIONS DROP." **The Chronicle of Higher Education**, March 2, 2001.

"*In 1995 the Pew Health Professions Commission predicted that the use of communication and robotics technologies by managed care companies would supplant pharmacists and create an oversupply. But demand for pharmacists is strong . . . and appears to be outpacing supply, defying earlier predictions.*" **BNA's Health Care Policy Report, August 2, 1999.**

"*. . . There's no druggist on duty. Now that an increased education requirement has caused a shortage of pharmacists, the law is inconveniencing . . . the education requirement—part of a nationwide professionalization drive—is directly responsible for the sudden pharmacist shortage. Connecticut pharmacy schools didn't graduate any classes this year; would-be graduates instead have . . . a sixth year. At the same time, fewer students are enrolling in pharmacy schools. Neighborhood pharmacist has never been a glamorous career choice, and the position's growing reputation for stress probably isn't adding any allure.*" "Closing Time", **Readers Guide**, 2001.

Headline: "NO PRESCRIPTION IN SIGHT FOR PHARMACIST SHORTAGE HIGH DEMAND FOR PRESCRIPTION DRUGS, FEWER APPLICANTS TO COLLEGES CREATE DEFICIT." **Duluth New-Tribune, 2000**

"*. . . here, the store has to be closed.—It's the law: A licensed pharmacist has to be in the building if the doors are open.*" "Pharmacy Competitors Pull Together in a Crisis", **The News Tribune, Tacoma** 2001.

NEW SURVEY SHOWS PHARMACIST SHORTAGE CONTINUES IN ALL HEALTH CARE SETTINGS

NACDS' January 2001 survey of 81 chain pharmacy companies found 6,564 open pharmacy positions. This indicates no improvement in filling needed pharmacist positions, since the number of pharmacist vacancies increased from 6,425 in the July 2000 survey. The pharmacist vacancy rate is up from 4,475 open positions in January 1999, and 5,940 positions in July 1999.

On June 5, 2001, the American Hospital Association (AHA) published the results of a survey, which explored the shortage of health care workers in hospitals across the country.[2] (AHA((((Responses from more than 700 hospitals pointed to substantial vacancies in hospital pharmacies. In particular the survey shows a 21% vacancy rate for pharmacists.

[2] "*American Hospitals in Midst of Workforce Shortage*", American Hospital Association Press Release, June 2001.

WHAT IS THE "MARKET" RESPONSE TO THE PHARMACIST SHORTAGE AND IS IT ENOUGH TO SOLVE THE PROBLEM?

Can the "market" alone solve this pressing problem of the pharmacist shortage? Right now, the demand for pharmacist is clearly exceeding the supply. We believe that a combination of private and public sector responses are needed to alleviate the shortage.

For example, the market is attempting to respond to this shortage in many different ways. Obviously, salaries for pharmacists have increased as a result of the shortage as various pharmacy practice settings compete with each other to attract pharmacists away from other practice settings. While this is clearly a normal market reaction to a shortage (when demand outstrips supply), the result is not in the best interest of public health since it is leaving key positions vacant in health care settings that need the services of a pharmacist. It is also draining faculty resources away from schools and colleges of pharmacy.

Economic theory would argue that, as salaries increased, pharmacy would become a more attractive option as compared to other occupations, or health professions, and more students would enter pharmacy, helping to alleviate the shortage. Salaries would fall as the supply increased, and the supply and demand for pharmacists would fall back into equilibrium.

This is true, in part, because there are indications that more applicants are starting to apply to schools of pharmacy. However, in economic terms, there are certain structural and financial "barriers to entry" that would argue that the market cannot "do it alone". Federal intervention is needed in the marketplace to help facilitate the restoration of the equilibrium between supply and demand of pharmacists.

For example, even with the salary increases, the nation's 83 schools and colleges of pharmacy have limited capacity to train students, and the implementation of the Doctor of Pharmacy (Pharm.D.) program has increased the cost of training each pharmacist. Schools have not been able to expand their physical training capacity as quickly as the demand has increased. School expansion generally requires more physical facilities (i.e., laboratories, classrooms, pharmacy clinical practice labs, and clinical practice sights) to satisfy pharmacy school accreditation requirements, and pharmacy schools often compete with other professional and technical schools for limited state or other funding sources for these infrastructure needs. Schools need Federal help to expand these training facilities.

Pharmacy education is further limited by the fact that pharmacy faculty are being drawn away by higher salaries from other practice settings. Pharmacists that may want to teach may not have the economic resources to do so because of their loan obligations. Thus, they may be attracted to higher-paying pharmacy practice positions, limiting the ability of schools to expand class sizes, even if they were able to expand their physical facilities. However, pharmacists may be willing to take pharmacy faculty positions if Federal loan repayment was available to them to help defray these educational costs. The Federal government has successfully operated a faculty loan repayment program for many years, focusing primarily on underserved areas and disadvantaged students. We believe that a similar program should be developed for pharmacy faculty.

Finally, as noted, pharmacist educational training requirements have increased from a minimum of five to a minimum of six years. Potential pharmacists have weighed the economic costs to them investing in a six year pharmacy education versus other career programs that may provide a similar economic reward. Many pharmacy students can access Federal loans available to four-year degree college students, such as Pell Grants and Stafford Loans.

However, pharmacists need at least two more years of professional training, and Federal educational resources become more scare and limited for pharmacy students in the last two professional years. If Federal educational loan and scholarship resources were available throughout the professional training, fewer pharmacy students would drop out of their programs due to financial constraints, and more prospective students would be attracted to a career in pharmacy.

Thus, simply relying on the "market" to solve this pharmacist shortage problem is unrealistic. The market can and is doing its part. However, we believe that Federal policymakers have a vested interest in assuring the existence of a strong pharmacy education infrastructure that will help improve the use of prescription medications, and reduce the tens of billions of dollars each year that the health care system spends on the adverse results of inappropriate medication use.

PROPOSED FEDERAL BUDGET CUTS WILL HARM EXISTING PHARMACY EDUCATIONAL PROGRAMS

NACDS believes that new Federal programs are needed to help alleviate the pharmacist shortage. But first, we believe that existing Federal programs that help to support the development and training of health professionals should be retained and strengthened.

For example, we are concerned that the President's proposed FY 2002 budget decreases by 60% funding for all Public Health Service (PHS) Title VII programs for which pharmacy students and colleges and schools of pharmacy are eligible. At a time when the demand for pharmacists far exceed the capacity of colleges and schools to increase the supply, creating financial and other infrastructure roadblocks (like reductions in the faculty loan repayment program), is a matter of great concern. Here are some examples of how existing Federal programs helped to support pharmacy education:

- In FY 2001, over 25% of pharmacy students were beneficiaries of Title VII "Scholarships for Disadvantaged Students" (SDS). Title VII funds helped to ensure the education of many pharmacists, who eventually practiced in community health centers and provided services to many of the nation's culturally diverse populations.
- In FY 2001, colleges and schools of pharmacy received a total of $5,716,718 for SDS. The average award per student was approximately $2250. Therefore, up to 2800 students were able to receive scholarships. The President's reduction decreases the number of students receiving Title VII scholarships by almost 1/3 to no more than 1100 students. This would jeopardize the education of nearly 1,600 pharmacy students, at a time when only 8,000 pharmacists graduate annually.

One way of solving the pharmacy shortage problem is by educating more pharmacists. Programs like SDS make it possible for students to take advantage of educational opportunities. Reducing funding to existing programs that assist students will likely decrease the number of students entering pharmacy schools, and lead less pharmacists entering the workforce.

SUPPORT THE "PHARMACY EDUCATION AID ACT OF 2001" (H.R. 2173)

NACDS strongly supports the bipartisan "*Pharmacy Education Aid Act of 2001*" (H.R. 2173), which will help to address the critical shortage of pharmacists in the United States. We appreciate the leadership shown by Congressmen Jim McGovern and Mike Simpson in introducing this important bill. We also appreciate the support of the other 33 Members of Congress who are cosponsoring this bill. We respectfully urge that other Members show their support for the 83 schools of pharmacy, thousands of pharmacy students and faculty, and pharmacists in practice, by supporting H.R. 2173.

The "**Pharmacy Education Aid Act of 2001**" addresses the pharmacist shortage problem by:

- **Creating Funding Source for Pharmacy School Infrastructure Renovation or Expansion:** Many pharmacy schools are in need of funds to help expand or modernize their facilities, install new laboratories, or upgrade computer technology in order to train pharmacists.

New technology also creates the opportunity to establish or expand distance learning programs. This bill would allow the Secretary of HHS to establish a program of grants and contracts for these purposes.

- **Expanding Existing Federal Funding Programs for Pharmacy Student Education:** Other than the grants and scholarships available to all college students, there are very limited Federal programs that specifically help to fund pharmacy student education. This bill would establish new Federal programs to help pharmacy students obtain loans and grants for their education to assure the availability of adequate funding throughout the student's entire professional pharmacy training.
- **Assuring Adequate Supply of Pharmacy Faculty:** Existing Federal faculty loan repayment and recruiting programs for health professional schools only help a small number of students pay off loans to encourage teaching as a career. This bill will expand these programs to provide Federal funds to schools to help pay the loans of doctoral-level pharmacists that agree to teach at the school for at least two years.

The Pharmacy Education Act is an important step in the process of increasing the number of pharmacists in the workforce, and is the appropriate Federal response

to work in tandem with the market to restore the balance in supply and demand of pharmacists.

CONCLUSION

Mr. Chairman, the available studies documenting the shortage of pharmacists, the continuing drumbeat of newspaper stories, and day-to-day experiences that our patients have with pharmacies that are closed or have reduced hours, demonstrate that there is a pharmacist shortage that must be addressed with a strong Federal response.

We urge you to take action this year on H.R. 2173, so that we can begin the process of restoring the important supply of pharmacists needed by our health care system to meet the increasing demand. We look forward to working with you and other Members of Congress on this important issue. Thank you.

PREPARED STATEMENT OF NATIONAL RURAL HEALTH ASSOCIATION

The National Rural Health Association appreciates the opportunity to submit the following testimony for the record on strengthening the safety net and increasing access to essential health care services in rural areas. Most rural providers and facilities play a safety net role, taking care of low-income and uninsured patients. In particular, we would like to focus on the vital role the National Health Service Corps (NHSC) and the Consolidated Health Centers (CHC) programs play in providing access to health care services in rural and urban underserved areas and the need for reauthorization of both of these programs this year, with specific modifications to allow them to better serve a greater proportion of rural Americans.

NATIONAL HEALTH SERVICE CORPS

Since 1972, over 20,000 NHSC clinicians have fulfilled a pledge to serve rural and urban underserved communities in exchange for scholarships or loan repayment. However, the NHSC currently meets only about 12% of the overall need for health care in underserved areas. Although the program received a modest increase in funding for Fiscal Year 2001 to $129.4 million, the NRHA believes that without additional funding, the program cannot even begin to meet the needs of rural America.

Reauthorization offers an opportunity to make modifications in the NHSC program that would strengthen the program and allow it to better fulfill its mission of increasing access to primary care services and reducing health disparities for people in health professional shortage areas by assisting communities through site development and by the preparation, recruitment and retention of community-responsive, culturally competent primary care clinicians. Working with a broad coalition of health care associations including the American Academy of Physician Assistants, American College of Nurse-Midwives, the American College of Nurse Practitioners, the American Dental Association, the American Dental Education Association, the American Medical Student Association, the American Psychological Association, the Association of American Medical Colleges, the Association of Clinicians for the Underserved, the National Association of Community Health Centers, the National Association of Rural Health Clinics and the National Organization of Nurse Practitioner Facilities, the NRHA has developed a list of recommendations for reauthorization of the NHSC program which includes the following:

1. Reauthorize the National Health Service Corps for five years at $300 million for the first year and for such sums as are necessary for each subsequent fiscal year.
2. Continue an annual report to Congress for evaluating the effectiveness of the NHSC programs, including community impact, allocation of scholarships and loan repayment by discipline, and efficacy of site development efforts.
3. Ensure that Federally Qualified Health Centers and Federally Certified Rural Health Clinics, which accept Medicare assignment and serve Medicaid patients without restrictions; utilize a sliding fee scale for patients below 200% of poverty, and serve all patients regardless of their ability to pay, shall be automatically eligible for placement of National Health Service Corps personnel.
4. Allow the NHSC to develop a pilot program under which scholarship and loan repayment program recipients could fulfill their commitment on a part-time basis. This option would only be available if such service is requested by 1) the placement site or sites as well as the scholarship and loan repayment recipients and 2) so long as the total obligation is fulfilled.
5. Allow the use of a voluntary "ready-reserve" of clinicians to serve in locum tenens (temporary relief) placements or to response to other episodic national needs.

6. Authorize funding for site development, which includes community needs assessment and technical assistance.

7. Allow private practice sites that would otherwise qualify as a NHSC site to be eligible for placements from the Community Scholarship and State Loan Repayment programs.

In order to be eligible, private practice sites would be required to meet the same standards as non-profit sites: 1) accept Medicare assignment and serve Medicaid patients without restrictions; 2) utilize a sliding fee scale for patients below 200% of poverty, and 3) serve all patients regardless of their ability to pay. Placement priority shall be given to not-for-profit sites, particularly in cases where both non-profit and for-profit sites serve the same population.

8. Assist communities and sites in developing incentives to support the retention of NHSC providers beyond their obligation.

9. Eliminate the community cost-sharing provision (Section 334 of the Public Health Service Act).

10. If necessary to use such a designation, use a definition of frontier which takes into account population density, distance in miles to the nearest service market, and travel time in minutes to the nearest service market.

Suggested Report Language:

11. Combine the Divisions of the National Health Service Corps and the Scholarship & Loan Repayment into a single division.

Related Recommendations:

12. Exclude from Federal income, FICA, and self-employment taxation tuition, fees and related educational expenses to individuals participating in the NHSC Loan Repayment, Community Scholarship and State Loan Repayment program. (The tax on NHSC Scholarship payments has already been repealed by passage of H.R. 1836 earlier this year.)

The recommendations outlined above would ensure the viability of the NHSC program, and strengthen the program so that it may continue serving millions of Americans and more efficiently respond to the needs of communities and match those needs with a health professional who fits those needs.

CONSOLIDATED HEALTH CENTERS

The Consolidated Health Centers Program is comprised of four parts: Community Health Centers, Migrant Health Centers, Health Care for the Homeless and Public Housing Primary Care.

Currently over 1,000 health centers serve more than 11 million patients across the nation. Community health centers (CHCs) are an important part of the rural safety net, providing care to the uninsured and underinsured who would otherwise lack access to health care, including 5.4 million rural residents (1 out of 10) and supporting the primary care infrastructure in those communities. Community health centers focus on wellness and prevention in addition to primary care services and foster community bonds through consumer boards governing each center.

The Rural Health Outreach and Network Development Grant Program is also authorized within the same legislation as the Consolidated Health Centers Program. This program serves to support innovative health care delivery systems as well as vertically integrated health care networks in rural America. Since 1991, over 2.7 million people in all but 4 states have been served by the Outreach and Network Development Grant Program through grants totaling over $200 million. The grants provide up to $200,000 a year for three years to each grantee. About 60 percent of grantees have continued to provide services beyond their federal grant period.

The Consolidated Health Centers program should be reauthorized this year. The National Rural Health Association advocates reauthorization of the CHC Program for five years at $1.344 billion for Fiscal Year 2002 and such sums as may be necessary for the following four fiscal years. As part of the reauthorization of Section 330 of the Public Health Service Act, the NRHA advocates the addition of several provisions aimed at strengthening this vital program. These changes include: the restoration of facility construction, modernization and expansion as allowable uses of funds; the expansion of authority to support CHC networks designed to improve health care delivery and efficiency; and restoration of the statutory requirement for proportional allocation of grant funding for the various components of the Consolidated Health Centers program. In reauthorizing the program, its ability to maintain the primary care infrastructure in rural medically underserved areas must be continued.

The Rural Health Outreach and Network Development Grant Program should also be reauthorized and its funding increased so that more communities can benefit

from these grants and the long-term improvement in the rural health care delivery system they foster. In Fiscal Year 2000, 138 active Outreach grants served over 7,000 rural residents. The program received funding of $30.9 million in Fiscal Year 2001, in addition to $20.4 in earmarked projects. The National Rural Health Association advocates reauthorization and increased funding for these grants of $50 million in Fiscal Year 2002.

The National Rural Health Association looks forward to continuing to work with the House Energy and Commerce Health Subcommittee and the Congress as a whole on the reauthorization of the National Health Service Corps, the Consolidated Health Centers and Rural Health Outreach and Network Development Grant Programs, as well as other important rural health issues, in the coming months. The NRHA is grateful for the attention given to these issues by Chairman Bilirakis and members of the Subcommittee and appreciates the opportunity to submit testimony on Authorizing Safety Net Public Health Programs.